

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |   |  |  |  |  | REG. NO. 8 2 1 2 9 6 0  |  |   |  |                             |  |  |  |
|---|--|--|--|--|---|--|--|--|--|---|--|---|--|-----------------------------|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |   |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 5-28-82  |  |   |  | 2b. HOUR 11:50 P.M.         |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Catherine Allison   |  |  |  |  |   |  |  |  |  |   |  |   |  |                             |  |  |  |
| 3. SEX F  |  |  | 4. RACE W  |  |   | 5. DATE OF BIRTH MONTH DAY YEAR July 27, 1911  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.  |   |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania  |  |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County MD.                                    |   |  |   |  |                             |  |  |  |
| 10. CITY OR TOWN OF DEATH Frederick   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife                      |   |  | 12b. KIND OF BUSINESS OR INDUSTRY Home  |  |                             |  |  |  |
| 13a. STATE Maryland   |  |  | 13b. COUNTY Frederick  |  |   | 13c. CITY OR TOWN Frederick  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS 218 East Church Street 21701 |   |  |                             |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lucien Summy  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Haverstick        |  |  |  |  |   |  |   |  |                             |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO  |  |  |  |  | 16b. SOCIAL SECURITY NO. 174-20-2198                                |  |  |  |  | 16c. INFORMANT ADDRESS Mrs. Genevieve M. Grove 636 Trail Ave. Frederick, MD 21701   |  |   |  |                             |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pulmonary Edema. 4149  |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 Hours   |  |   |  |                             |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Underlying Chronic Pulmonary Disease   |  |  |  |  |   |  |  |  |  | 1 year  |  |   |  |                             |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |   |  |  |  |  |   |  |   |  |                             |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |   |  |  |  |  |   |  |   |  |                             |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                             |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |                             |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>                                    |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |                             |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/28/82 to 5/28/82, that (II) (we) last saw the deceased alive (above) (I) (we) (did) and not view the body after death. |  |  |  |  |   |  |  |  |  | 19 82 to 5-28/ 19 82, the (II) (we) last saw the deceased alive (above) (I) (we) (did) and not view the body after death. |  |   |  |                             |  |  |  |
| 22b. SIGNATURE Robert L. Kaufmann, M.D.   |  |  |  |  |   |  |  |  |  | DEGREE  |  | 22c. DATE SIGNED 5/29/82  |  |                             |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Robert L. Kaufmann, M.D.  |  |  |  |  |   |  |  |  |  | 22e. ADDRESS 804 Toll House Ave. Frederick, MD 21701  |  |   |  |                             |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  |  |  |  | 23b. DATE June 1, 1982  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery Frederick, Frederick, MD   |  |   |  |                             |  |  |  |
| 24. FUNERAL DIRECTOR Smith, Keeney & Basford 106 East Church St. Frederick, MD 21701  |  |  |  |  |   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR JUN 3 1982  |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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502-2-52

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100 West 4th Street, New York, N.Y. 10014

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |  |  |  |  |  |  |  | REG. NO. 8 2 1 2 9 6 1   |  |   |  |          |  |
|---|--|----------------------|--|--|--|--|--|--|--|--|--|---|--|----------|--|
| 1. FOR STATE REGISTRAR  |  |                      |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH  |  | 2b. MONTH DAY YEAR                        |  | 2c. HOUR |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Ronald Robert Bailey  |  |                      |  |  |  |  |  |  |  | ESTIMATED <input type="checkbox"/> 5 14 19 82                                    |  | 6 30 PM                                   |  |          |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasian |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Feb. 24 1940 43 YEARS   |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>5 14 19 82                            |  | 2d. HOUR                                  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County MD.                     |  |   |  |          |  |
| 10. CITY OR TOWN OF DEATH<br>Thurmont   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>US Route 15 North |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Meatcutter  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>None |  |          |  |
| 13a. STATE<br>Maryland  |  |                      |  | 13b. COUNTY<br>Frederick   |  | 13c. CITY OR TOWN<br>Thurmont  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br>13103 Catoctin Furnace Road                               |  |   |  |          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Grover Bailey  |  |                      |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Dorothy Elizabeth Thompson                           |  |  |  |  |  |   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>Yes   |  |                      |  | 16b. SOCIAL SECURITY NO.<br>Peacetime 160-32-7759  |  | 17. INFORMANT ADDRESS<br>Mr William Prince 1001 Rockville Pike Rockville, Md 20852                 |  |  |  |  |  |   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multis Trauma - Evisceration</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                      |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |   |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                      |  |  |  |  |  |  |  |  |  |   |  |          |  |
| 19a. DATE OF OPERATION  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY MONTH DAY YEAR<br>1850 5 14 82   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Motorcycle Injury |  |  |  |  |  |   |  |          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Highway   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>US 15 Frederick Md                               |  |  |  |  |  |   |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                      |  |  |  |  |  |  |  |  |  |   |  |          |  |
| ACTUAL SIGNATURE<br>Robert J. Thomas  |  |                      |  | TITLE (SPECIFY)<br>M.D. Deputy   |  |  |  | MEDICAL EXAMINER<br>DATE SIGNED 5/14/82  |  |  |  |   |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Robert J. Thomas, M.D.   |  |                      |  | ADDRESS<br>812 Toll House Ave. Frederick, Md. 21701  |  |  |  |  |  |  |  |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |                      |  | 23b. DATE<br>5-17-1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Blue Ridge Cemetery  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Thurmont, Frederick, Md               |  |   |  |          |  |
| 24. Robert E. Bailey & Son PA615 E. Main Thurmont, Md 21788   |  |                      |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 21 1982   |  | 25b. REGISTRAR'S SIGNATURE<br>Anne J. [Signature]  |  |  |  |   |  |          |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health officer death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and examined.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 7 2 1 2 9 6 2   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Edward J. Brazzerol</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 31, 1982</b>  |  | 2b. HOUR<br><b>10:00AM</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Cauc.</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 25, 1893</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>88</b><br>YRS. MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Myersville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>344 P Vista Ct.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Painter</b>  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Pr. Geo.</b>  |  | 13c. CITY OR TOWN<br><b>Ft. Wash</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Christian Brazzerol</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Schanberger</b>  |  | 17. ADDRESS<br><b>Robert Brazzerol same as item 13</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWI 579-60-0443</b>   |  | 17. ADDRESS<br><b>Robert Brazzerol same as item 13</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4289</b><br>IMMEDIATE CAUSE (a) <b>Cardiac Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CHF + Severe Emphysema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Atherosclerosis</b>   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>days</b><br><b>years</b><br><b>years</b>   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>no</b>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 24</b> , 19 <b>82</b> , to <b>May 31</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>May 24</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Charles R Wierker MD</b>  |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>5-31-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles R Wierker MD</b>   |  |   |  | 22e. ADDRESS<br><b>Box 173, Myersville Md 21773</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>6/2/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington Va.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.</b>  |  |   |  | 25. DATE REC'D. BY REGISTRAR<br><b>JUN 4 1982</b><br>REGISTRAR'S SIGNATURE<br><i>James J. ...</i>   |  |  |  |

C.P. Kates 640 Oxon Hill Rd. Oxon Hill, Md.

Initial 8/2/82 Arlington National Cem. Arlington Va.

Charles R. Kates and his wife, Mary Ann Kates  
Charles R. Kates  
Mary Ann Kates  
8-21-82

yes WAF 579-60-0443 Robert Kates] same as item 13

Christian Bremerol Mary Schenck  
No. Tr. Geo. Wt. Wash x 3711 Laurel Dr.  
Myersville 3419 P Vista Ct. Hettie Painter

Wash D.C. USA Frederick  
Male Gene. July 25, 1893 88

Edward J. Bremerol May 31, 1982 10:00AM



BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

item 14 #G568 6/28/82 ph

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Betty Chapman Brooking</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5-31-82</b>                                |   | 2b. HOUR<br><b>3:15 PM</b>                   |
| 1 SEX<br><b>FEMALE</b>   | 4 RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 16 1922</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pa.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>FREDERICK</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>FREDERICK</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FREDERICK MEMORIAL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |   |   | 13b. COUNTY<br><b>HOWARD</b>   |   | 13c. CITY OR TOWN<br><b>MT. AIRY</b>         |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM C. CHAPMAN</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LUELLA MCCROY</b>                |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>219-12-3394</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>2-D Breeze Branch Court</b><br><b>Mr. Robert F. Brooking Timonium, Md. 21093</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>TERMINAL METASTATIC BREAST CANCER</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>TO BONES AND LUNGS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2</b> 19 <b>80</b> , to <b>5-31</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>5-31</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death.  |   |   |  |   |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |   |   |  | 22c. DATE SIGNED<br><b>6-1-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ARTHUR G. MANALO, M.D.</b>   |   |   |  | 22e. ADDRESS<br><b>GIVEN UNUSUALLY nonprovia, md. 21770</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>   |   | 23b. DATE<br><b>6/1/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| 23d. LOCATION<br>CITY OR TOWN  |   | 23e. COUNTY   |  | 23f. STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 1 1982</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |   |   |  |   |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |   |  |  |  |
|---|--|--|--|---|--|---|---|--|--|--|
| 1 - FOR STATE REGISTRAR   |  |  |  |   | REG. NO. 8 2 1 2 9 6 4   |   |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>George Theodore Bruchey Sr.</b>  |  |  |  |   | 2a. DATE OF DEATH MONTH <b>31</b> DAY <b>5</b> YEAR <b>1982</b> 7:00 PM                |   |   |  |  |  |
| 3 SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>18</b> YEAR <b>1910</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.                                       |   | IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> IF UNDER 24 HRS. HOURS <b>0</b> MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County MD.</b>                      |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Frederick</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Farmer</b>          |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Agricultor</b>                             |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  |  |   | 13b. COUNTY<br><b>Frederick</b>  |   | 13c. CITY OR TOWN<br><b>Frederick</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <b>Charles</b> MIDDLE <b>Edward</b> LAST <b>Bruchey</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Carrie</b> MIDDLE <b>Mae</b> LAST <b>McKinney</b> |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-36-0462</b>   |  | 17. INFORMANT<br><b>Evelyn Bruchey</b> ADDRESS <b>7910 Runnymede Dr. Frederick, Maryland</b>  |  |   |   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4100 Autocoronary infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |  |  |   |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Coron</b>  |  |  |  |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Philip Chapman</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>    |  |   |   | 22c. DATE SIGNED<br><b>6/1/82</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Philip Chapman</b>  |  |  |  | 22e. ADDRESS<br><b>8147011 House Ave.</b>   |  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>6/3/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Frederick</b> COUNTY <b>Frederick</b> STATE <b>Md.</b> |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>G. Douglas Stauffer</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 7 1982</b>  |  |   |   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John Stauffer</b>  |  |  |  |   |  |   |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification must be completed.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |  |   |  | 7 2 1 2 9 6 5 |  |
|---|--|---|--|---|--|--|--|---|--|---------------|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |  |  |   |  | REG. NO.      |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>William Gabriel Burgee</b>  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>5/25/82</b>  |  | 2b. HOUR <b>8:00pm</b>  |  |               |  |
| 3. SEX <b>M Male</b>  |  | 4. RACE <b>White W.</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>5 22 1910</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YES  |  | 7. IF UNDER 1 YEAR: MONTHS DAYS HOURS MIN.  |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County MD.</b>                             |  |   |  |               |  |
| 10. CITY OR TOWN OF DEATH <b>Frederick</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Frederick Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tax Asseser</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>County</b>   |  |               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Frederick</b> 13c. CITY OR TOWN <b>Frederick</b>   |  |   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>611 Magnolia Ave.</b>  |  |               |  |
| 14. FATHER'S NAME FIRST <b>Eli</b> MIDDLE <b>McSherry</b> LAST <b>Burgess</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Nettie</b> MIDDLE <b>Day</b> LAST <b>Day</b>  |  |  |  |   |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>  |  | 16b. SOCIAL SECURITY NO. <b>WWII</b>  |  | 17. INFORMANT <b>Frances Burgee</b>   |  | ADDRESS <b>611 Magnolia Ave. Frederick, Md. 21701</b>  |  |   |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>myocardial Infarction, Ant</b><br>(c) <b>Arterio sclerotic Coronary Art Dis. years</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immed</b><br><b>Immed</b> |  |   |  |   |  |  |  |   |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>renal Failure</b>   |  |   |  |   |  |  |  |   |  |               |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |               |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1974</b> , 19____, to <b>5/25</b> , 19____, that (I) (we) last saw the deceased alive on <b>10/17</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |   |  |               |  |
| 22b. SIGNATURE <b>James Frizzell, M.D.</b>  |  |   |  | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>           |  |  |  | 22c. DATE SIGNED <b>5/25/82</b>   |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James A. Frizzell</b>  |  |   |  | 22e. ADDRESS <b>300 Park Ave, Frederick, Md</b>   |  |  |  |   |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>5/28/82</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frederick, Frederick, Md</b>                      |  |   |  |               |  |
| 24. FUNERAL DIRECTOR NAME <b>G. Douglas Stauffer</b>  |  |   |  | 16210 Possumtown Pike   |  | 25. REGISTRAR'S SIGNATURE <b>June 2 1982</b>   |  |   |  |               |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |   |  |  |  |  |
|--|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>NAOMI ELIZABETH CAMERON   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>May 10, 1982 |   |   | 2b. HOUR<br>6:31 P.M.  |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 13, 1903   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.                         |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick Co. MD.          |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>housewife |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>own home  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  |  |  | 13b. CITY OR TOWN<br>Frederick  |   | 13c. STREET ADDRESS<br>1331 Taney Ave.                             |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE A. WISE   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>EDITH KATE LONG  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-03-9191   |  | 17. INFORMANT ADDRESS<br>B Ray M. Cameron Frederick, Md. 21701  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br><u>4100</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ACUTE RECURRENT MYOCARDIAL INFARCTION</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> |  |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |  | 22b. SIGNATURE<br><u>Dr. Gilcin F. Meadors Jr.</u> DEGREE MD |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Gilcin F. Meadors Jr.   |  |  |  | 22d. ADDRESS<br>Toll House Ave., Frederick, Md.   |   |  |  | 22e. DATE SIGNED<br>5/15/82                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>May 13, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Reformed Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Middletown Fred. Md. |  | 23e. DATE REC'D. BY REGISTRAR<br>MAY 19 1982                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Thompson Funeral Home  |  | 24b. ADDRESS<br>21769 Middletown, Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 19 1982  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Thompson</u>                      |  |  |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it must be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |                            |   |  |  |  |  |  |
|--|--|---|---|---|----------------------------|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Harold Montrose Carrico</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 11 82</b> |   | 2b. HOUR<br><b>8:40 PM</b> |   |  |  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 6, 1912</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County, MD.</b>                            |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |   |   |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Saleman</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br><b>Penn.</b>   |  | 13b. COUNTY<br><b>Airville</b>  |   | 13c. CITY OR TOWN   |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>Woodbine Rd. rt 2</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William M. Carrico</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ruth A. Maslin</b>  |                            |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>579-09-7603</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Ruth Slidham Same as # 13e</b>  |                            |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Emphysema</b><br><b>4920</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |   |   |                            |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)  |  |   |   |   |                            |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>NA</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |                            | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>NA</b>   |                            |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/11</b> 19 <b>82</b> , to <b>5/11</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>5/11</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)            |  |   |   |   |                            |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Harold Carrico</b>  |  |   |   | DEGREE<br><b>MD</b>   |                            |   |  | 22c. DATE SIGNED<br><b>5/11/82</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Harold Carrico</b>   |  |   |   | 22e. ADDRESS<br><b>198 Hanon Johnson Pl Frederick, Md.</b>  |                            |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5/14/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore</b>  |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc.</b>   |  |   |   | ADDRESS<br><b>Baltimore, Md.</b>  |                            | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 13 1982</b>   |  | 25b. REGISTRAR<br><b>James J. Ruck</b>   |  |  |  |

BP

Name: William M. Carrico  
 Address: 11111  
 City: Baltimore  
 State: Md.  
 Zip: 21201  
 Phone: 570-00-7001  
 Mrs. Carrico Home no. 150

Leonard J. Rich, Inc.  
 Baltimore, Md.  
 5/1/80  
 Baltimore  
 Baltimore, Maryland  
 May 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 7 2 1 2 9 6 8   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH   |  |  |  |
| MELUA LILLIAN CLEVENGER  |  |  |  | 5 19 82 3 50 A M  |  |  |  |
| 3. SEX<br>Female.  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>March 18, 1905  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County, MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR BUSINESS DURING LIFE)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Frederick   |  | 13c. CITY OR TOWN<br>Tuscarora  |  | 13e. STREET ADDRESS<br>4127 Rock Hall Road   |  |
| 14. FATHER'S NAME<br>Charles Baker   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>Anna Shry   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) No  |  |  |  | 16b. SOCIAL SECURITY NO.<br>None  |  | 17. INFORMANT<br>Mrs. Bliz, Hanes, 5404 George St., Adamstown, Md.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARCINOMA OF THE COLON<br>1539<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 1/2 YRS   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (his hospital) attended the deceased from 10/21 74, to 5/17 82, that (II) (we) lost saw the deceased alive above (I) (we) (did) (did not) view the body after death.   |  | 22b. SIGNATURE<br>Wayne Algaier  |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>5/19/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WAYNE ALGAIER   |  | 22e. ADDRESS<br>BRUNSWICK, MD.   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>May 22, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Pauls Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Point of Rock, Fred., Md.  |  |
| 24. FUNERAL DIRECTOR<br>Richard C. C. Basford<br>Smith, Keeney and Basford Funeral Home<br>106 East Church St., Frederick, Md., 21701  |  |  |  | 25a. DATE<br>MAY 23 1982  |  |  |  |

REGISTRAR'S SIGNATURE  
Name Gas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 8 2 1 2 9 6 9  |  |   |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  |
| REG. NO.   |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM DONALD CORNELIUS</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 19, 1982</b>                           |  | 2b. HOUR<br><b>4:30</b> AM   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 24, 1912</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick Co.</b> MD.                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>conductor</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>railroad</b>   |  |
| 13a. STATE<br><b>Md.</b>   |  |   |  | 13b. CITY OR TOWN<br><b>Fred.</b>   |  | 13c. STREET ADDRESS<br><b>3512 Petersville Rd.</b>                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LEWIS H. CORNELIUS</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DAISY RUSSELL</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>719-01-3052</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mildred Cornelius Knoxville, Md.</b>                  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>4860</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>3 recent cerebro-vascular accidents</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/18</b> 19 <b>82</b> , to <b>5/19</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>W. Allgaier</b>   |  |   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>5/21/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Wayne Allgaier</b>   |  |   |  | 22e. ADDRESS<br><b>Brunswick, Md.</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>May 22, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Park Hgts. Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brunswick, Md.</b>                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John T. Williams F. H. Brunswick, Md.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 26 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>                            |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

|   |  |   |  |
|---|--|---|--|
| Item 2a 8567 5/24/82 gj   |  | STATE OF MARYLAND   |  |
| 1- STATE REGISTRAR  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE                             |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | REG. NO.  |  |
| FRANCIS HENRY DARNER  |  | 7 2 1 2 9 7 0   |  |
| 2a. DATE OF DEATH   |  | MONTH DAY YEAR  |  |
| 5 - 2 - 82  |  | 2b. HOUR  |  |
| 3. SEX  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Male  |  | 8 7 YRS   |  |
| 4. RACE   |  | IF UNDER 1 YEAR   |  |
| White   |  | MONTHS DAYS   |  |
| 5. DATE OF BIRTH  |  | IF UNDER 24 HRS   |  |
| 8 - 3 - 94  |  | HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Md.   |  | Frederick Co. MD.   |  |
| 7b. CITIZEN OF WHAT COUNTRY?  |  | 12a. USUAL RESIDENCE (TYPE OF WORK FOR MOST OF WORKING LIFE)        |  |
| U.S.A.  |  | Retired Service Manag. Utility                                      |  |
| 10. CITY OR TOWN OF DEATH   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Frederick   |  | Utility   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 13a. STREET ADDRESS   |  |
| Frederick Memorial Hospital   |  | 217 E. Main St.   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. INSIDE CITY LIMITS?  |  |
| Md. Fred. Middletown  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |
| GEORGE FREDERICK DARNER   |  | CARRIE SHAFF  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO OR UNKNOWN, NO)   |  | 17. INFORMANT ADDRESS   |  |
| NO  |  | Frances R. Darner Middletown, Md.                                   |  |
| 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |  |
| 219-10-3634   |  | Frances R. Darner Middletown, Md.                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| IMMEDIATE CAUSE (a) 5609 ASPIRATION PNEUMONIA   |  | 4 DAYS  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) POSSIBLE PARTIAL BOWEL OBSTRUCTION   |  | 5 "   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) PARKINSON'S DISEASE   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |
| -   |  | -   |  |
| 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY   |  |
|   |  | HOUR A.M. MONTH DAY YEAR  |  |
|   |  | P.M. 19   |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY  |  |
| AT WORK <input type="checkbox"/> NOT WORK <input type="checkbox"/>  |  | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]                      |  |
| 21f. LOCATION   |  | 21g. LOCATION   |  |
| STREET  |  | CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/27/1982 to 5/1/1982, that (I) (we) last saw the deceased alive on 5/1/1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death. |  |   |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED  |  |
| James L. Roessler MD  |  | 5/1/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |
| JAMES L. ROESSLER MD  |  | MIDDLETOWN, MARYLAND 21769  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  |
| Burial  |  | May 4, 1982   |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |
| Reformed Cem.   |  | Middletown Fred. Md.  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR                                       |  |
| Thompson Funeral Home   |  | MAY 10 1982   |  |
| 25b. REGISTRAR'S SIGNATURE  |  |   |  |
|   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |   |  |  |  |  |
|--|--|--|--|---|---|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  |   |   |  |  |  |  |
| 8 2 1 2 9 7 1  |  |  |  |   |   |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |   |   |  |  |  |  |
| REG. NO.   |  |  |  |   |   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John Francis DAVIS  |  |  |  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>MAY 21, 82                                    |  |  |  |
| 3. SEX<br>Male   |  |  |  |   |   | 2b. HOUR<br>10:30 P.M.   |  |  |  |
| 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 27, 1906  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75   |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County, MD                         |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Gas Co.   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Carroll 13c. CITY OR TOWN Keymar   |  |  |  |   |   |  |  |  |  |
| 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 11418 Baker Road  |  |  |  |   |   |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John William Davis   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Florence Wastler |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no  |  |  |  |   | 16b. SOCIAL SECURITY NO.<br>217-10-0523                           |  |  |  |  |
| 17. INFORMANT<br>ADDRESS<br>Mrs. James R. Boone, same as above   |  |  |  |   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 5334 CARDIOPULMONARY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY INSUFFICIENCY<br>DUE TO, OR AS A CONSEQUENCE OF (c) Adult Respiratory Distress, Aspiration Pneumonia<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5/21/82<br>5/7/82<br>5/7/82 |  |  |  |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>C.V.A. Large Gastrodual Ulcer  |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION<br>5/7/82   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>MASSIVE UPPER G.I. Bleeding  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from May 5, 1982, to May 21, 1982, that (b) (we) last saw the deceased alive on May 21, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (do) view the body after death.  |  |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br>James S. Grissom M.D.  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   |  |  | 22c. DATE SIGNED<br>5/21/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JAMES S. GRISSON M.D.   |  |  |  | 22e. ADDRESS<br>198 Thomas Johnson Dr., Suite 4, Frederick, Md. 21701   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>May 25, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Frederick Frederick Md.                |  |  |  |
| 24. FUNERAL DIRECTOR<br>Smith Keeney Bassford P., Funeral Home<br>106 E. Church St., Frederick, Md. 21701  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 25 1982  |   | 25b. REGISTRAR'S SIGNATURE<br>James J. [Signature]                                   |  |  |  |

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THEORY

Estuaries and Coasts

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| <p>Item #6 per phone call w/Fuh.<br/>1- STATE Home 6/23/82 rc<br/>REGISTRAR</p> <p>8 2 1 2 9 7 2<br/>CERTIFICATE OF DEATH<br/>REG. NO.</p>  |  |   |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>William E. Dorsey</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 -24-82</b>  |  | 2b. HOUR<br><b>6:00P</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 19 16</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66 65</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Frederick</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick MD.</b>                                    |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Citizens Nursing Home</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Meat Cutter</b>          |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Fred.</b>   |  | 13c. CITY OR TOWN<br><b>Woodshoro</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>503 Adam Street</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Owen Dorsey</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Betsy Shorb</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Unknown No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-18-0394</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Ronald Dorsey 503 Adam St. Woodshoro</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>3030</b><br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Infection</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic alcoholism</b>                                     |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>3 months</b><br><b>years</b>                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11b.  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 27 1982</b> to <b>May 24 1982</b> that (I) (we) last saw the deceased alive on <b>May 23 1982</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (we) (we) did not see the body after death. |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>James Crosby MD</b>  |  |   |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>5/24/82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES CROSBY MD</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>801 Tollhouse Frederick Md.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5/27/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Hope Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick Md.</b>                              |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>G. Douglas Stauffer</b>  |  |   |  |   |  | 25. DATE REC'D. BY REGISTRAR<br><b>JUN 2 1982</b>   |  |   |  |
| 25. REGISTRAR'S SIGNATURE<br><b>James Crosby</b>  |  |   |  |   |  |   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |  |  |   |  |   |  | 8   | 2 | 1  | 2 | 9   | 7 | 3 |
|--|--|--|---|--|--|---|--|---|--|---|---|--|---|---|---|---|
| 1 - FOR STATE REGISTRAR  |  |  |   |  |  |   |  |   |  | REG. NO.  |   |  |   |   |   |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CHARLES F EYLER</b>  |  |  |   |  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>May 18, 1982</b>   |   |  |   | 2b. HOUR<br><b>10:00 PM</b>                 |   |   |
| 3. SEX<br><b>Male</b>  |  |  | 4. RACE<br><b>Caucasian</b>   |  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>May 5, 1905</b>   |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b>   |   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>    |   | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>MD</b> |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick,</b>  |   |   |  |   |   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>KKKK Citizens Nursing Home</b> |  |  |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret Railroad</b>                                       |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b> |   |   |   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |  |  |   |  |   |  | 13a. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13b. STREET ADDRESS<br><b>Route # 1</b>          |   |   |   |   |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Frederick</b>   |  |  | 13c. CITY OR TOWN<br><b>Rocky Ridge</b>   |  |   |  |   |   |  |   |   |   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Charles Martin Eyer</b>  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Annie Gilbert</b>   |   |  |   |  |   |   |  |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>705-10-6268</b>  |  |  | 17. INFORMANT ADDRESS<br><b>Mr Charles F Eyer, Jr Rocky Ridge, Md</b>   |  |   |  |   |   |  |   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Cardio-vascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebral arterio-sclerosis with hemiplegia</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c):<br><b>Cerebral arterio-sclerosis with hemiplegia</b> |  |  |   |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>109</b>                                      |   |  |   |   |   |   |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |   |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |   |  |   |   |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |   |  |   |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1</b> 19 <b>79</b> to <b>May 18</b> 19 <b>82</b> , that (I) ( ) lost saw the deceased alive on <b>May 18</b> 19 <b>82</b> , and that in (my) ( ) opinion death occurred on the date and hour and from the causes stated above, (I) ( ) did not view the body after death.   |  |  |   |  |  |   |  |   |  |   |   |  |   |   |   |   |
| 22b. SIGNATURE<br><b>Bernard O. Thomas, Jr</b>   |  |  |   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |   |  | 22c. DATE SIGNED<br><b>5-18-1982</b>  |   |  |   |   |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Bernard O Thomas, Jr MD</b>  |  |  |   |  | 22e. ADDRESS<br><b>228 N Market Street Frederick, Md 21701</b>   |   |  |   |  |   |   |  |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>5-21-1982</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Tabor Lutheran Cem</b>  |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Rocky Ridge, Frederick, Md</b>   |   |   |  |   |   |   |   |
| 24. FUNERAL DIRECTOR<br><b>Robert E Dalley &amp; Son PA</b>  |  |  |   |  | 615 East Main Street<br>Thurmont, Md 21701   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 21 1982</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>                                       |   |  |   |   |   |   |

BP

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text follows, appearing to be a memorandum format with various fields and lines of text.]

[Large block of illegible text, likely the main body of the memorandum or report.]

Very truly yours,  
[Illegible Signature]  
Special Agent in Charge

Enclosure

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   | 8 2 1 2 9 7 4<br>REG. NO.  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ALBERT LUTHER FINNEYFROCK</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 1 82</b>                           |  |  | 2b. HOUR<br>MIN.<br><b>3:20</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>November 16, 1910</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>71</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County</b> MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Driver</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bowers Lumber</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Frederick</b>   |  | 13c. CITY OR TOWN<br><b>Frederick</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>404 East Patrick St. 21701</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert Luther Finneyfrock, Sr.</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Mae Freed</b>         |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214-10-1745</b>   |  | 16c. ADDRESS<br><b>404 East Patrick St. Frederick, MD 21701</b><br><b>Mrs. Nellie E. Finneyfrock</b>  |  |  |  |   |  |
| 18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Multiple Aortic Aneurysm-recurrent</b><br><b>4416</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 19 58</b> to <b>5-1-82</b> , that (I) (we) lost<br>saw the deceased alive on <b>4-30-19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Rex R Martin MD</b>  |  |   | DEGREE<br><b>MD</b>  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5-1-82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Rex R Martin</b>  |  |   | 22e. ADDRESS<br><b>220 N. Market Frederick MD, 21701</b>               |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |   | 23b. DATE<br><b>May 4, 1982</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Luke's Cemetery</b>               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Feagaville, Frederick, MD</b> |   |  |
| 24. FUNERAL DIRECTOR<br><b>Smith, Keeney &amp; Basford Keith H. Watson</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 6 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |
| 106 East Church St. Frederick, MD 21701   |  |   |  |   |  |  |  |   |  |

BP

Robertson, James

1910-11-10

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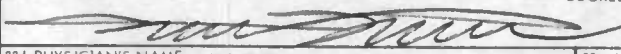
1910-11-10

1910-11-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours, both with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 2 1 2 9 7 5   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Mary Ellen Fogle</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 22 82</b>   |  | 2b. HOUR<br><b>8:50 A</b> M  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 29 01</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick</b> MD.  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Frederick</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Frederick</b>   |  | 13c. CITY OR TOWN<br><b>Walkersville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Fietz</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Minnie Mae Nash</b>   |  | 13e. STREET ADDRESS<br><b>8511 Water Street Rd.</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-88-5522</b>  |  | 17 INFORMANT<br><b>Mary Fauver</b>  |  | ADDRESS<br><b>Walkersville</b>   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b><br>2030<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Coronary atherosclerosis</b><br>(c) <b>Multiple myeloma</b> |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3</b>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>Chronic pulmonary disease, Organic heart disease</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>18 Feb 82</b> to <b>22 May 82</b> , that (I) (most) saw the deceased alive on <b>21 May 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>  |  |   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>29 May 82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Galen F. Brooks, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>4 W. Seventh St. Frederick</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5/25/82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glade Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Walkersville, Fdk, Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>G. Douglas Stauffer</b>   |  |   |  | 1621 Opossumtown Pk. Frederick, Md. JUN 2 1982  |  |  |  |



Female

White

Frederick

Frederick

Frederick

Frederick

Frederick

Frederick

Frederick

Frederick

William

Frederick

Frederick

Frederick

Frederick

Frederick

Frederick

*[Faint, illegible handwriting]*

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*[Faint, illegible handwriting]*

Allen F. Brooks, Jr.

Allen F. Brooks, Jr.

Frederick

Frederick

Frederick

Frederick

Frederick

Frederick



79

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. IF YOU ARE TO BE A FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                         |   |   |   |   |
|--|-------------------------|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Thiron Phillip Gibson</b>  |                         |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH <b>5</b> DAY <b>22</b> YEAR <b>87</b> |   | 2b. HOUR<br><b>AM</b>   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>11</b> YEAR <b>30</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>52</b> YRS.                                | IF UNDER 1 YR.<br>MONTHS _____ DAYS _____   | IF UNDER 24 HRS.<br>HOURS _____ MIN. _____  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kentucky</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>15414 Motter Station Rd.</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Grounds Keeper</b>  |   |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Frederick</b>   |   | 13c. CITY OR TOWN<br><b>Rocky Ridge</b>   |   |
| 14. FATHER'S NAME<br>FIRST <b>James</b> MIDDLE <b>Phillip</b> LAST <b>Gibson</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Corby</b> MIDDLE <b>Ritchie</b> LAST <b>Ritchie</b>  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>375-40-8628</b>  |   | 17. INFORMANT<br><b>Nancy Gibson</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4292 Atherosclerotic Cardiovascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hours</b>   |   |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.  |                         |   |   |   |   |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |   |   |   |   |
| ACTUAL SIGNATURE<br><b>Robert J. Thomas</b>  |                         | TITLE (SPECIFY)<br><b>Deputy</b>  |   | DATE SIGNED<br><b>5/24/87</b>   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Robert J. Thomas, M.D.</b>  |                         | ADDRESS<br><b>812 Toll House Ave<br/>Frederick, Maryland 21701</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>5/26/87</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Resthaven Mem. Gar.</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>G. Douglas Stauffer</b>   |                         | ADDRESS<br><b>Frederick, Md.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick, Frederick, Md.</b>  |   |
| 25. DATE REC'D BY REGISTRAR<br><b>5/24/87</b>  |                         | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |   |   |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 2 1 2 9 7 7

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |  |  |   |  |   |  |  |
|--|--|---|--|--|--|---|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Shirley Joann Grossnickle</b>   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 31 1982</b>                       |  |  | 2b HOUR<br><b>2:15 pm</b>   |  |   |  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 23 1944</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>38</b> YRS.                                    |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick</b> MD.                         |  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Smithsburg</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>13618 John Kline Road</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b> |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a STATE<br><b>Maryland</b>   |  |   | 13b COUNTY<br><b>Frederick</b>   |  | 13c CITY OR TOWN<br><b>Smithsburg</b>  |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e STREET ADDRESS<br><b>13618 John Kline Road</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David D. Dick</b>  |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>N. Marea McPherson</b>         |   |  |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217 42 7636</b> |  | 17 INFORMANT<br><b>13618 John Kline Rd.<br/>Richard Grossnickle Smithsburg, MD</b> |   |  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the Breast</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 years</b>  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>n/a</b>   |  |   |  |  |  |   |  |   |  |  |
| 19a DATE OF OPERATION  |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |  |   |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |   |  |  |
| 22a I certify that (I) <b>ME Money MD.</b> attended the deceased from <b>6/16/</b> 19 <b>80</b> to <b>present</b> 19 <b>82</b> .<br>saw the deceased alive on <b>5/28</b> 19 <b>82</b> , and that in (my) <b>ME</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>ME</b> (did) <b>ME</b> view the body after death.   |  |   |  |  |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>ME Money MD.</b>  |  |   |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>6/1/82</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mary E. Money, M. D.</b>   |  |   |  |  |  | 22e ADDRESS<br><b>1708 Oak Hill Avenue Hagerstown, MD 21740</b>                     |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>6-3-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Marks Cemetery</b>                    |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Wolfsville Frederick MD</b>                   |   |  |  |
| 24 FUNERAL DIRECTOR<br>NAME <b>Dennis Z. Bittle-Ricketts</b><br>ADDRESS <b>Myersville MD</b>   |  |   |  |  |  | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 8 1982</b>                                   |  | 25b REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>  |  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12114

CONFIDENTIAL



Shirley Jean Grossnickle 31 1942

Female 1 23 1944 30

Married U.S.A. 21 1944

Secretary 1945 John Line Road

Married 1945 John Line Road

David O. Dick 1945 John Line Road  
217 22 1945 Richard Grossnickle Secretary

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CONFIDENTIAL 12114

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |  |  |   |   |   |  |
|---|--|--|---|--|--|---|---|---|--|
| 1 - FOR STATE REGISTRAR   |  |  |   |  |  |   |   |   |  |
| CERTIFICATE OF DEATH  |  |  |   |  |  |   |   |   |  |
| REG. NO. 8 2 1 2 9 7 8  |  |  |   |  |  |   |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>MARGARET ELIZABETH HEERD   |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br>5 17 82 225A M  |   |   |   |  |
| 3. SEX F  |  | 4. RACE W  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 29 09   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.   |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Frederick CO MD.                             |   |   |  |
| 10. CITY OR TOWN OF DEATH Frederick   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FREDERICK MEMORIAL HOSP |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker           |   | 12b. KIND OF BUSINESS OR INDUSTRY - - - - -   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY FREDERICK 13c. CITY OR TOWN FREDERICK  |  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS 800 MOTTER AVE  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST HARRY B. ALLEN  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CAROLINE WYNKOOP  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no  |  |  |   |  | 16b. SOCIAL SECURITY NO. - - - - - 214-10-5465   |   | 17. INFORMANT ADDRESS Mr. Allen L. Heerd, 6557-A Wycombe Way, Baltimore, Maryland 21234 |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK<br>4100<br>DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCT<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) ISCHEMIC HEART DISEASE<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 HR<br>28 HR<br>YEARS |  |  |   |  |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) HYPERTENSION  |  |  |   |  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)    |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-16 19-82, to 5-17 19-82, the (I) (we) last saw the deceased alive on 5-12 19-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.  |  |  |   |  |  |   |   |   |  |
| 22b. SIGNATURE S. Kahan   |  |  |   |  | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED 5-17-82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. KAHAN  |  |  |   |  | 22e. ADDRESS 335 PARK AVE FREDERICK MD   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  |  | 23b. DATE May 20, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery   |   | 23d. LOCATION Frederick Frederick Md.   |   |  |
| 24. FUNERAL DIRECTOR Smith Keeney Baileford Funeral Home, 106 E. Church St., Frederick, Md. 21701   |  |  |   |  | 25. DATE REC'D. BY REGISTRAR MAY 19 1982   |   | 25a. REGISTRAR'S SIGNATURE  |   |  |

MEDICAL CERTIFICATION

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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |   |  |  |   |  |  |
|---|--|--|---|---|--|--|---|--|--|
| 1- FOR STATE REGISTRAR  |  |  |   |   | 8 2 1 2 9 7 9  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  |  |
| CATHERINE IRENE HEWITT<br><i>Catherine Irene Hewitt</i>   |  |  |   |   | 5-17-82 10 <sup>10</sup> P.M.  |  |   |  |  |
| 3. SEX  |  | 4. RACE  |   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | 7. IF UNDER 1 YEAR   |  |
| Female  |  | Caucasian  |   | December 20, 1930   |  | 51 YRS.  |   | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |  |
| Maryland  |  | USA  |   |   |  | Frederick MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Frederick   |  | Frederick Memorial Hospital  |   |   |  | Homemaker  |   | None   |  |
| 13a. STATE  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |   | 13e. STREET ADDRESS  |  |
| Maryland  |  | Frederick  |   | Thurmont  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 14933 Kelbaugh Road  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  |   |  |  |
| Charles Donnelly  |  |  |   | Ida Catherine Miller  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |  |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |   |  |  |
| No  |  |  |   | 220-26-0080   |  | Mr Melvin Hewitt 14933 Kelbaugh Road Thurmont, Md 21788  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <i>respiratory arrest</i>   |  |  |   |   |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>adeno ca lung mts to</i>  |  |  |   |   |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>bone &amp; brain</i>  |  |  |   |   |  |  |   |  | 12 mo  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |   |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |
|   |  |  | P.M. 19   |   |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |  |
|   |  |  |   |   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1981</i> , 19 <i>5/17</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>5/17</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |   |  |  |
| 22b. SIGNATURE  |  |  | DEGREE  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED   |  |
| <i>[Signature]</i>  |  |  |   |   |  |  |   | 5/17/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS  |   |  |  |   |  |  |
| <i>[Signature]</i>  |  |  | 44 West Seventh St  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |  |
| Burial  |  |  | 5/21/82   |   | Resthaven Mem Gardens  |  | Frederick, Frederick, Md                |  |  |
| 24. FUNERAL DIRECTOR  |  |  | 25a. DATE REC'D. BY REGISTRAR                                       |   |  | REGISTRAR'S SIGNATURE  |   |  |  |
| Robert E Dailey & Son 615 East Main St  |  |  | MAY 21 1982   |   |  | <i>[Signature]</i>   |   |  |  |
| Funeral Homes, P. A.  |  |  | Thurmont, Md 21788  |   |  |  |   |  |  |

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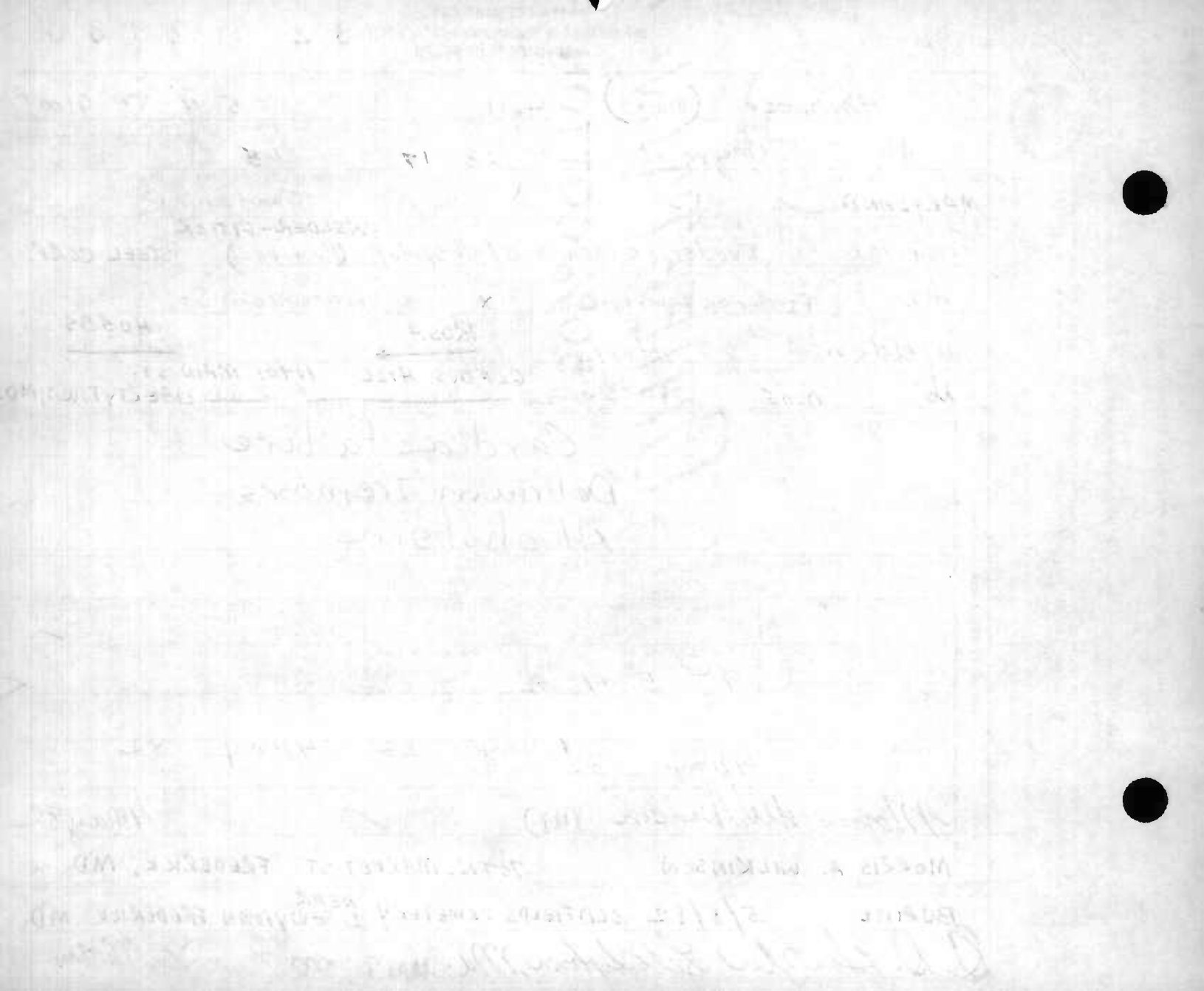
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |  |  |  |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Ambrose (NMN) Hill</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5 4 82</b> |   |  | 2b. HOUR<br><b>9:00</b> <sup>A</sup> <sub>M</sub>  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>Negroid</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1 23 17</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>65</b> YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>STEEL CORP.</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE<br><b>MD</b>  |  |  |   | 13c. CITY OR TOWN<br><b>Frederick</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Weldon Hill</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Rosa Gladys Roberts</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-05-6035</b>   |   | 17. INFORMANT<br><b>GLADYS HILL 11901 MAIN ST. FULLER LIBERTYTOWN, MD</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac failure</b><br>2910<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Delirium Tremors</b><br>(c) <b>Alcoholism</b>             |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>9 P.M. 5 4 82</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1 May 1982</b> to <b>4 May 1982</b> , that (I) (we) last saw the deceased alive on <b>4 May 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Morris A. Wilkinson</b> MD   |  |  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>4 May 82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MORRIS A. WILKINSON</b>   |  |  |   | 22e. ADDRESS<br><b>707 N. MARKET ST. FREDERICK, MD.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  | 23b. DATE<br><b>5/8/82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OLDFIELDS CEMETERY</b>   |  | 23d. LOCATION<br><b>NEAR LIBERTYTOWN FREDERICK MD.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>D. D. Hartzler</b> Libertytown, Md.  |  |  |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>MAY 7 1982 Thomas Van Natten</b>   |  |  |  |

BP



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## MEDICAL CERTIFICATION

| STATE OF MARYLAND   |  |  |   |  |  |  |  |  |   |  |  |
|---|--|--|---|--|--|--|--|--|---|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |  |  |  |  |  |   |  |  |
| CERTIFICATE OF DEATH  |  |  |   |  |  |  |  |  |   |  |  |
| REG. NO. 8 2 1 2 9 8 1  |  |  |   |  |  |  |  |  |   |  |  |
| 1. FOR STATE REGISTRAR  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  |   | 2b. HOUR                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT) ANNA Delores Hill  |  |  |   |  | 5.25.82  |  |  |  |   | 11:12 P                                      |  |
| 3. SEX Female   |  | 4. RACE White  |   | 5. DATE OF BIRTH MONTH DAY YEAR Mar.22, 1919   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS                             |  | IF UNDER 1 YEAR MONTHS DAYS                    |   | IF UNDER 24 HRS. HOURS MIN.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.   |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Frederick Co. MD.             |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH Frederick   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) cook |  | 12b. KIND OF BUSINESS OR INDUSTRY food service |   |  |  |
| 13a. STATE Md.  |  |  | 13b. COUNTY Fred.   |  | 13c. CITY OR TOWN Brunswick  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS 206 N. Delaware Ave.  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Fiersuk  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Unknown                   |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No  |  |  | 16b. SOCIAL SECURITY NO. 213-18-3174                                |  | 17. INFORMANT Richard Hill   |  | ADDRESS 7094 Winter Rose Path Columbia, Md.  |  |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |   |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) extensive small cell ca 1974  |  |  |   |  |  |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) metastases to bone, lung, 2 yr   |  |  |   |  |  |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) liver resp arrest terminal   |  |  |   |  |  |  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |   |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/80, 1980, to 5/25, 1982. Not (I) (we) lost saw the deceased alive on 5/25, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |  |   |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE [Signature]  |  |  |   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED 5/25/82  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature]   |  |  |   |  | 22e. ADDRESS 4 West Seventh  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  |  | 23b. DATE May 29, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY Locust Valley Bible                         |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Middletown Fred. Md.   |  |   |  |  |
| 24. FUNERAL DIRECTOR NAME John T. Williams ADDRESS Funeral Home Brunswick, Md.  |  |  |   |  |  |  |  |  |   |  |  |





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## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |                                      |  | 8 2 1 2 9 8 2  |  |  |  |
|--|--|---|--|---|--|--------------------------------------|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH   |  |                                      |  | 2b. HOUR   |  |  |  |
| Melvin OSCAR HOAR  |  |   |  | 5/28/82   |  |                                      |  | 6:25 A.M.  |  |  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE                               |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.   |  |
| Male   |  | White   |  | Jan. 16, 1905   |  | 77 YRS.                              |  | MONTHS   |  | DAYS   |  |
| 7a. BIRTHPLACE   |  | 7b. CITIZEN OF WHAT COUNTRY?                            |  | 8. MARRIED  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |  |  |
| Md.  |  | U.S.A.  |  | NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>            |  | Frederick                            |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  | 12a. OCCUPATION   |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |  |  |  |  |
| Frederick  |  | Frederick Memorial Hospital                             |  | dispatcher  |  | railroad                             |  |  |  |  |  |
| 13a. STATE   |  |   |  | 13b. COUNTY   |  |                                      |  | 13c. CITY OR TOWN  |  |  |  |
| Md.  |  |   |  | Fred.   |  |                                      |  | Brunswick  |  |  |  |
| 14. FATHER'S NAME  |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |                                      |  |  |  |  |  |
| JAMES W. HOAR  |  |   |  | GERTRUDE M. MERRIMAN  |  |                                      |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |   |  | 16b. SOCIAL SECURITY NO.  |  |                                      |  | 17. INFORMANT  |  |  |  |
| No   |  |   |  | 212-03-5901   |  |                                      |  | Edna A. Hoar   |  |  |  |
| 18. CAUSE OF DEATH   |  |   |  | 19. STREET ADDRESS  |  |                                      |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                                      |  |  |  |  |  |
| IMMEDIATE CAUSE (a) 4292   |  |   |  | Congestive Heart Failure  |  |                                      |  | one year   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  | (b) Atherosclerotic Cardiovascular Disease  |  |                                      |  | years  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  | (c)   |  |                                      |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |                                      |  |  |  |  |  |
| Diabetes Mellitus  |  |   |  |   |  |                                      |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                                      |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |   |  |   |  |                                      |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY   |  |                                      |  | 21c. HOW INJURY OCCURRED                                 |  |  |  |
| (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | HOUR A.M. MONTH DAY YEAR  |  |                                      |  | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |  |  |
|  |  |   |  | P.M. 19   |  |                                      |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  |   |  | 21e. PLACE OF INJURY  |  |                                      |  | 21f. LOCATION  |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |                                      |  | STREET CITY OR TOWN COUNTY STATE                         |  |  |  |
|  |  |   |  |   |  |                                      |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/20/82 to 5/28/82, that (I) (we) lost saw the deceased alive on 5/27/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated |  |   |  |   |  |                                      |  |  |  |  |  |
| 22b. SIGNATURE   |  |   |  | DEGREE  |  |                                      |  | 22c. DATE SIGNED   |  |  |  |
| Casper E. Cliner   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                                      |  | 5/28/82  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS  |  |                                      |  |  |  |  |  |
| Casper E. Cliner   |  |   |  | 804 Hill House Ave  |  |                                      |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |   |  | 23b. DATE   |  |                                      |  | 23c. NAME OF CEMETERY OR CREMATORY                       |  |  |  |
| Burial   |  |   |  | May 31, 1982  |  |                                      |  | Dark Heights Cem.  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |   |  | 25a. DATE BY REGISTRATION   |  |                                      |  | 25b. SIGNATURE   |  |  |  |
| John T. Williams   |  |   |  | Brunswick, Md.  |  |                                      |  | JUN 7 1982   |  |  |  |
| NAME   |  |   |  | ADDRESS   |  |                                      |  |  |  |  |  |
| John T. Williams Funeral Home  |  |   |  |   |  |                                      |  |  |  |  |  |

RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.  
OFFICE OF THE SECRETARY  
ATTENTION: ASSISTANT SECRETARY  
FOR AGRICULTURAL POLICY  
AND  
ECONOMICS  
MAIL ROOM  
MAIL STOP 100  
WASHINGTON, D.C. 20250

TO: DIRECTOR, AGRICULTURAL  
RESEARCH SERVICE  
WASHINGTON, D.C.  
FROM: ASSISTANT SECRETARY  
FOR AGRICULTURAL POLICY  
AND ECONOMICS  
SUBJECT: [Illegible]  
DATE: [Illegible]  
[Illegible text follows]

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BP

DHMH - 16 50M 1-B1  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| 24 1 - FOR STATE REGISTRAR<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |
| FIRST MIDDLE LAST  |  |  |  |  | MONTH DAY YEAR HOUR  |  |  |  |  |
| CHARLES DEWEY HODGE  |  |  |  |  | 5 19 82 5:30 P.M.  |  |  |  |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | 7b. IF UNDER 24 HRS.   |  |
| Male   |  | White  |  | MONTH DAY YEAR<br>July 28, 1921  |  | 60 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |
| Virginia   |  | U.S.A.   |  |  |  | Frederick County, MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Frederick  |  | Frederick Memorial Hospital  |  |  |  | Driver   |  | Coca Cola Plant  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  | 13b. CITY OR TOWN  |  | 13c. STREET ADDRESS                      |  |  |
| 13a. STATE COUNTY<br>West Va. Berkley  |  |  |  |  | 13b. CITY OR TOWN<br>Harpers Ferry   |  | 13c. STREET ADDRESS<br>Route 3, Box 1340 |  |  |
| 14. FATHER'S NAME  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |
| FIRST MIDDLE LAST<br>Charles Dewey Hodge   |  |  |  |  | FIRST MIDDLE LAST<br>Nona Lee Robbins  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |  |  |
| No   |  |  | None   |  | not available Mrs. E. Ruth Nichols, 1901-A Jefferson Pike, Knoxville, Md. 21758  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Respiratory Failure  |  |  |  |  |  |  |  |  | 3 days                                       |
| 4960 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Pulmonary Disease  |  |  |  |  |  |  |  |  | 5 years                                      |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |  |  |  |  |  |  |
| 28 Previous gastrectomy  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                   |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                       |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
|  |  |  | P.M. 19  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 5/19/82, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death. |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  | DEGREE   |  |  | 22c. DATE SIGNED   |  |
| James S. Grissan MD  |  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 5/19/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |
| JAMES S. GRISSAN MD  |  |  |  |  | 198 Thomas Johnson Dr. Suite 4 Frederick MD  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |
| Entombment   |  |  | May 22, 1982   |  | Resthaven Mem. Gardens   |  | Frederick, Frederick, Md.                |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  | 25a. DATE BY REGISTRAR 25b. REGISTRAR SIGNATURE  |  |  |  |  |
| Smith, Keeney and Basford Funeral Home<br>106 East Church St., Frederick, Md. 21701  |  |  |  |  | MAY 25 1982  |  |  |  |  |

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• 2007 2008 2009

1901-2, Letter to Mr. [illegible]  
[illegible] [illegible] [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |   |   |   |  |   | 1 2 9 8 4                                    |                          |                 |     |         |          |  |
|---|--|---|--|--|---|---|---|--|---|--|--------------------------|-----------------|-----|---------|----------|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  | REG. NO.  |   |   |  |   |  |                          |                 |     |         |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |  | FIRST MIDDLE LAST   |   |   |  |   | 2a. DATE OF DEATH                            |                          | MONTH           | DAY | YEAR    | 2b. HOUR |  |
| EVON EVETRIAL JACKSON   |  |   |  |  |   |   |   |  |   | 5  |                          | 2               | 82  | 5:10 PM |          |  |
| 3 SEX   |  | 4 RACE  |  | 5 DATE OF BIRTH  |   |   | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  |   | IF UNDER 1 YEAR                              |                          | IF UNDER 24 HRS |     |         |          |  |
| Female  |  | Negro   |  | August 28 1895   |   |   | 87  |  |   | MONTHS DAYS                                  |                          | HOURS MIN.      |     |         |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9 BALTIMORE CITY OR COUNTY OF DEATH  |   |  |                          |                 |     |         |          |  |
| Maryland  |  | U.S.A.  |  |  |   |   |   | Frederick MD.  |   |  |                          |                 |     |         |          |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY            |                          |                 |     |         |          |  |
| Frederick   |  | Frederick Memorial Hospital   |  |  |   |   |   | Housewife  |   | Home   |                          |                 |     |         |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  | 13a. STATE  |   | 13b. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS      |                 |     |         |          |  |
|   |  |   |  |  | Maryland  |   | Frederick   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 5506 A Burkittsville Rd. |                 |     |         |          |  |
| 14. FATHER'S NAME   |  |   |  |  | 15. MOTHER'S MAIDEN NAME  |   |   |  |   |  |                          |                 |     |         |          |  |
| FIRST MIDDLE LAST   |  |   |  |  | FIRST MIDDLE LAST   |   |   |  |   |  |                          |                 |     |         |          |  |
| George Albert Whalen  |  |   |  |  | Altie Clara Holland   |   |   |  |   |  |                          |                 |     |         |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  |  | 16b. SOCIAL SECURITY NO.  |   | 17 INFORMANT  |  |   |  |                          |                 |     |         |          |  |
| No  |  |   |  |  | 215 20 9162   |   | 3861 S. Mountain Rd.<br>Clifford Morris Knoxville, Maryland         |  |   |  |                          |                 |     |         |          |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial infarction<br>4100<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Victim<br>(c) Auto Helio Crashdown de |  |   |  |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                          |                 |     |         |          |  |
|   |  |   |  |  |   |   |   |  |   | 126  |                          |                 |     |         |          |  |
|   |  |   |  |  |   |   |   |  |   | 126  |                          |                 |     |         |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |   |  |  |   |   |   |  |   |  |                          |                 |     |         |          |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  |   |   | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                          |                 |     |         |          |  |
|   |  |   |  |  |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                          |                 |     |         |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |   |  |   |  |                          |                 |     |         |          |  |
|   |  |   |  |  |   |   |   |  |   |  |                          |                 |     |         |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |   |  |   |  |                          |                 |     |         |          |  |
|   |  |   |  |  |   |   |   |  |   |  |                          |                 |     |         |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 65, to 5/2 19 82, that (I) (we) last saw the deceased alive on 5/2 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.    |  |   |  |  |   |   |   |  |   |  |                          |                 |     |         |          |  |
| 22b. SIGNATURE<br>Robert S. Hughes, M.D.  |  |   |  |  |   | DEGREE<br>M.D.                                    |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>5/3/82                   |                          |                 |     |         |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert S. Hughes, M.D.   |  |   |  |  |   | 22e. ADDRESS<br>700 Montclair Ave. Frederick, Md. |   |  |   |  |                          |                 |     |         |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |   |  |                          |                 |     |         |          |  |
| Burial  |  |   | 5/6/82   |  | Petersville Meth. Cdm Petersville Maryland  |   |   |  |   |  |                          |                 |     |         |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John T. Williams F. H. Brunswick, Maryland  |  |   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 21 1982      |   |  |   |  |                          |                 |     |         |          |  |
|   |  |   |  |  |   | 25b. REGISTRAR'S SIGNATURE<br>Charles J. H. H. H. |   |  |   |  |                          |                 |     |         |          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the funeral director. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |   |  |  |   |   |   |  |
|---|--|---|---|---|---|--|--|---|---|---|--|
| 1- FOR STATE REGISTRAR  |  |   |   |   |   |  |  |   |   |   |  |
| REG. NO. 8 2 1 2 9 8 5  |  |   |   |   |   |  |  |   |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Guy <del>Robert</del> Princeton Johnson   |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>5-1-82  |  | 2b. HOUR<br>9 A.M.   |   |   |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>10 6 93  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS                                  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN |   |   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><del>Frederick</del> Frederick MD. |  |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Citizens Nursing Home |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>theater                |   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE COUNTY<br>Md. Carroll   |  |   |   |   | 13c. CITY OR TOWN<br>Keymar   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br>947 F.S.K. Highway   |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George Johnson   |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Margaret Groff  |  |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  |   |   |   | 16b. SOCIAL SECURITY NO.<br>W W I 577-18-55B  |  | 17. INFORMANT ADDRESS<br>947 Francis Scott Key   |   |   | 17. INFORMANT<br>Dorothy S. Bowers Keymar, Md. Hwy. |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiac arrest</u><br>4140<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>XISHD</u><br>(c) <u>104 yrs</u>   |  |   |   |   |   |  |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |   |  |  |   |   |   |  |
| MEDICAL CERTIFICATION   |  |   |   |   |   |  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/20</u> , 19 <u>81</u> , to <u>5/1</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>4/20</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |   |   |  |  |   |   |   |  |
| 22b. SIGNATURE<br>J. Hickey   |  |   |   |   | 22c. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22d. DATE SIGNED<br>5/6/82                                  |   |   |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. Hickey  |  |   |   |   | 22f. ADDRESS<br>516 Truett Frederick Md   |  |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>5/4/82   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Haugh's Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Ladiesburg Frederick Md.                          |   |   |   |  |
| 24. FUNERAL DIRECTOR NAME<br>DD Hartzler - New Windsor Md.  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 13 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>Therese Ann Martin   |   |   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for price.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |   |  |
|--|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 8 2 1 2 9 8 6  |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Lillie S. KEFAUVER</b>   |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>May 18, 1982</b>                                      |  | 2b. HOUR<br><b>a.m.</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>July 10, 1885</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>96</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County, MD.</b>                         |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Homewood Retirement Center</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>- - - - -</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN<br><b>Maryland Frederick Frederick</b>   |  |   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>417 Delaware Road</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Jesse Haines</b>   |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary E. Ramsburg</b>                        |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>  |  |   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>217-10-0748</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs. Mildred K. Forney, 417 Delaware Road, Frederick, Maryland 21701</b>                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery accident</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>4360</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>many years</b> 19____, to <b>5/18/82</b> 19____, that (we) last saw the deceased alive on <b>5/17/82</b> 19____, and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (we) (they) (did not) view the body after death.                           |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Austin Pearre, Jr.</b> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |  |  |  | 22c. DATE SIGNED<br><b>5/18/82</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. A. Austin Pearre, Jr. MD</b>   |  |   |  |  |  | 22e. ADDRESS<br><b>804 Toll House Ave., Fred. Md. 21701</b>                                  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>May 21, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Frederick Frederick Md.</b>                    |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Smith Keeney Basford P.A. Funeral Home</b>  |  |   |  |  |  | 25. DATE RECD. BY REGISTRAR<br><b>MAY 20 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James Van Natten</b>   |  |
| 106 E. Church St., Fred. Md. 21701   |  |   |  |  |  |  |  |   |  |

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Robert H. Johnson

U.S.A.

Frederick Proctor

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Dr. J. Austin Foster, Jr. MD. 501 Tenth Avenue, Fred. Md. 21 10

THE UNIVERSITY OF CHICAGO

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                      |  |  |  |                             |   |  |  |  | REG. NO. 12987   |  |
|--|----------------------|--|--|--|-----------------------------|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Donald Richard Kelly</b>   |                      |  |  |  |                             |   |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>5</b> DAY <b>7</b> YEAR <b>1982</b> |  |
| 3. SEX <b>Male</b>   | 4. RACE <b>White</b> | 5. DATE OF BIRTH MONTH <b>Aug.</b> DAY <b>13</b> YEAR <b>1928</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS. | IF UNDER 1 YR. MONTHS <b>8</b> DAYS <b>24</b>  | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD MONTH <b>5</b> DAY <b>7</b> YEAR <b>1982</b>       |  | 2d. HOUR <b>7:30</b>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick Co., MD.</b>              |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Mt. Pleasant</b>  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kelly Rd.</b> |  |  |                             | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Miller</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Feed Mill</b>                                 |  |  |  |
| 13a. STATE <b>Maryland</b>   |                      | 13b. CITY OR TOWN <b>Frederick</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                             | 13e. STREET ADDRESS <b>11 Frederick Ave.</b>                                |  |  |  |  |  |
| 14. FATHER'S NAME FIRST <b>Raymond</b> MIDDLE <b>L.</b> LAST <b>Kelly</b>  |                      |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Belva</b> MIDDLE <b>G.</b> LAST <b>Wiles</b>   |                             |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |                      | 16b. SOCIAL SECURITY NO. <b>213-28-6006</b>  |  | 17. INFORMANT ADDRESS <b>Evelyn R. Kelly, Same As #13</b>  |                             |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>9530</b> IMMEDIATE CAUSE (a) <b>Hanging</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <b>Hanging</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |                      |  |  |  |                             |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                      |  |  |  |                             |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |                      |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                             |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                      |  |  | 21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Hanging</b>   |                             |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                      |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Feed Mill</b>   |                             |   |  | 21f. LOCATION (STREET, CITY OR TOWN, COUNTY, STATE) <b>Kelly Rd. Frederick Md.</b> |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER           |                      |  |  |  |                             |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Robert J. Thomas</b>   |                      |  |  | DATE SIGNED <b>5/7/82</b>  |                             |   |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Robert J. Thomas, M.D.</b>  |                      |  |  | ADDRESS <b>812 Toll House Ave. Frederick, Maryland 21701</b>   |                             |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |                      | 23b. DATE <b>5-10-1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>   |                             | 23d. LOCATION (CITY OR TOWN, COUNTY, STATE) <b>Frederick, Md.</b>           |  |  |  |  |  |
| 24. FUNERAL DIRECTOR <b>Charles W. Burrier, Jr., Sykesville, Md.</b>   |                      |  |  |  |                             | 25a. DATE REC'D. BY REGISTRAR <b>MAY 11 1982</b>                            |  | 25b. REGISTRAR'S SIGNATURE <b>James J. ...</b>                                     |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. *Signature of physician may be retained by the hospital or attending physician.*

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Lowell, Han 19

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 2 1 2 9 8 8

1- FOR STATE REGISTRAR  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Harley Junior Lowe</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 24 82</b>  |  | 2b. HOUR<br><b>6:56 PM</b>   |
| 3 SEX<br><b>Male</b>   | 4 RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 2 1924</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County MD.</b>  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Engineer</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bd. of Ed.</b>                               |  |
| 13a. STATE<br><b>Maryland</b>  |   |   | 13b. COUNTY<br><b>Frederick</b>  | 13c. CITY OR TOWN<br><b>Frederick</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Curtis Lowe</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Effie May Quinn</b>  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>211-14-4796</b>  | 17. INFORMANT<br>ADDRESS<br><b>Geraldine Mercer 225 E. 5th St. Frederick, Md.</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>asthma</b><br><b>4939</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>seizure disorder</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>NA</b> |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| 19a. DATE OF OPERATION<br><b>NA</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>NA</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>NA</b>  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>NA</b>   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>NA</b>   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19 80</b> to <b>May 24</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>April</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Med Asthman</b>   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>5/24/82</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lowell E. Asthman</b>  |   |   | 22e. ADDRESS<br><b>198 Hanna Johnson Ave</b>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>5/28/82</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Union Chapel Cetty</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Libertytown, Frederick, Md.</b>     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>G. Douglas Stauffer</b>   |   |   | 25. DATE REC'D. BY REGISTRAR<br><b>1621 Opossumtown Pk...</b>  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 8 2 1 2 9 8 9<br>REG. NO.   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>KATHRYN G. LYON   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>5 28 82   |  | 2b. HOUR a m<br>9:50 a   |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>3 16 02  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pa.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County MD.                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Nursing Center |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Admin.        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Consulting                                      |  |
| 13a. STATE<br>Md.   |  |  |  | 13b. COUNTY<br>Frederick  |  | 13c. CITY OR TOWN<br>Frederick   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Judson A. Lyon   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Almina Baer   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  |  |  | 16b. SOCIAL SECURITY NO.<br>705-03-4801   |  | 17. INFORMANT ADDRESS<br>Mr. William Anders 1041 N. Market St. Frederick, Md.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>atrial fibrillation</u>  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/18/82</u> , 19_____, to <u>5/28/82</u> , 19_____, that (we) lost saw the deceased alive on <u>5/19/82</u> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.       |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Amelia Barry</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  |  |  | 22c. DATE SIGNED<br>5/28/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal  |  |  |  | 23b. DATE<br>5/28/82  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR NAME<br>Anatomy Board  |  |  |  | ADDRESS<br>Balto., Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 7 1982                                    |  | 25b. REGISTRAR'S SIGNATURE   |  |

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D.C.

| No. |  | Date |  | Locality |  | Collector |  | Plant |  | Fruit |  | Seed |  | Notes |  |
|-----|--|------|--|----------|--|-----------|--|-------|--|-------|--|------|--|-------|--|
| 1   |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 2   |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 3   |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 4   |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 5   |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 6   |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 7   |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 8   |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 9   |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 10  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 11  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 12  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 13  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 14  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 15  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 16  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 17  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 18  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 19  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 20  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 21  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 22  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 23  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 24  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 25  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 26  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 27  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 28  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 29  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 30  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 31  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 32  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 33  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 34  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 35  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 36  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 37  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 38  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 39  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 40  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 41  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 42  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 43  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
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| 47  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 48  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 49  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 50  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 51  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 52  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 53  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 54  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 55  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 56  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 57  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 58  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 59  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 60  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 61  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 62  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 63  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 64  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 65  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 66  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 67  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 68  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 69  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 70  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 71  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 72  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
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| 74  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 75  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
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| 86  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
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| 89  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
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| 94  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
| 95  |  |      |  |          |  |           |  |       |  |       |  |      |  |       |  |
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CHIEF  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/B1  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |   |   |                               |  |  |                            |
|--|--|---|--|---|---|---|-------------------------------|--|--|----------------------------|
| 1- FOR STATE REGISTRAR   |  |   |  |   | 8 2 1 2 9 9 0   |   |                               |  |  |                            |
| CERTIFICATE OF DEATH   |  |   |  |   | REG. NO.  |   |                               |  |  |                            |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>IRWIN (NMN) MALEK</b>   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR 5-12-82  |   |                               |  |  | 2b. HOUR 8 <sup>15</sup> M |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR 12 1 1900  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.                         |                               | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  |                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Hungary</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County MD</b>        |                               |  |  |                            |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |                               | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                            |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                               |  |  | 13e. STREET ADDRESS        |
| 13a. STATE<br><b>Florida</b>   |  | 13b. COUNTY<br><b>Palm Beach</b>  |  | 13c. CITY OR TOWN<br><b>Boynton</b>   |   | 300 NE 26th Avenue  |                               |  |  |                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Tovais Malek</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah "unknown"</b>           |   |                               |  |  |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT<br><b>Gertrude "Wife"</b>   |   |   | ADDRESS<br><b>Same as 13e</b> |  |  |                            |
| 16a. <b>No</b>   |  | 16b. <b>158-26-5096</b>   |  |   |   |   |                               |  |  |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>hepatic coma</b><br>5768<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>obstructive jaundice of</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Unknown etiology</b><br>2 mo<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |   |   |                               |  |  |                            |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |   |   |                               |  |  |                            |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |                               |  |  |                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |                               |  |  |                            |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |                               |  |  |                            |
| 22b. SIGNATURE<br>   |  |   |  |   | DEGREE  |   | 22c. DATE SIGNED<br>5/12/82   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Dovais</b> |                            |
| 22e. ADDRESS<br><b>4 West Seneca</b>   |  |   |  |   |   |   |                               |  |  |                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>5-14-82</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Beth Davis</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Elmont Nassau NY</b>     |                               | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 14 1982</b>  |  |                            |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>1601 Pennsylvania Avenue</b>  |  |   |  |   | 25b. REGISTRAR'S SIGNATURE<br>  |   |                               |  |  |                            |
| <b>Rest Haven Funeral Chapel Hag., MD</b>  |  |   |  |   |   |   |                               |  |  |                            |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |   |   |  |  |  |                         |
|--|--|--|--|---|---|---|--|--|--|-------------------------|
| 8 2 1 2 9 9 1  |  |  |  |   |   |   |  |  |  |                         |
| CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |  |  |                         |
| REG. NO.   |  |  |  |   |   |   |  |  |  |                         |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Raymond O. MATHEWS</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 8, 1982</b>   |   |  |  |  | 2b. HOUR<br><b>a.m.</b> |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 31, 1914</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |                         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County, MD.</b>                            |  |  |  |                         |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5115 Cap Stine Rd. (Residence)</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Farming</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>- - - -</b>  |  |                         |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Frederick</b>  |  | 13c. CITY OR TOWN<br><b>Frederick</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5115 Cap Stine Road</b>  |  |                         |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Arthur Mathews</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Gracie Magaha</b>   |   |  |  |  |                         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>- - - -</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Mary E. Mathews (same as above)</b>   |   |   |  |  |  |                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral M.D. &amp; heart arrested</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Coronary Sclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>7 yrs</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs</b> |  |  |  |   |   |   |  |  |  |                         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |   |   |  |  |  |                         |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                         |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |  |  |  |                         |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |                         |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 1974</b> , to <b>May 8, 1982</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |   |  |  |  |                         |
| 22b. SIGNATURE<br><b>Dr. A. Talbott Brice</b>  |  |  |  |   | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>5/10/82</b>   |  |                         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. A. Talbott Brice M.D.</b>  |  |  |  |   | 22e. ADDRESS<br><b>Jefferson, Maryland 21755</b>  |   |  |  |  |                         |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Feagaville Frederick Md.</b>                   |  |  |  |                         |
| 24. FUNERAL DIRECTOR<br><b>Smith Keeney Basford Funeral Home</b>   |  | 25. DATE RECD. BY REGISTRAR<br><b>MAY 14 1982</b>  |  | 25b. SIGNATURE<br><b>E. Church St., Frederick, Maryland 21701</b>   |   |   |  |  |  |                         |



May 8, 1982

MARYLAND

Raymond

88

Jan. 31, 1981

State

State

Frederick County

U.S.A.

Maryland

Frederick 2112 Cap Stine Rd. (Residence) Hunting

Maryland Frederick Frederick

Maryland

Frederick

Maryland

Maryland

Mr. Mary E. Hadden (name as above)

212-36-6570

no

Dr. A. Talbot Price M.D. Jefferson, Maryland 21755

Frederick May 11, 1982 Mr. Lunde's Den. Maryland's Frederick Co.

Frederick County, Maryland 21701

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 7 2 1 2 9 9 2   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH   |  |  |  |
| FIRST MIDDLE LAST<br>CARL CASHOUSE May   |  |  |  | MONTH DAY YEAR HOUR<br>May 27, 1982 11:47 A   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 22, 1908  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County, MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Driver  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Brick Company   |  |
| 13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>Frederick  |  | 13c. CITY OR TOWN<br>Frederick   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John William May   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br>Grace Botin   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>None  |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Lily L. May, 1000 Heather Ridge Drive<br>Frederick, Md. 21701  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>4960<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <u>RESPIRATORY ARREST</u><br>(c) <u>SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u>  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>JULY</u> 19 <u>78</u> , to <u>MAY</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>26 MAY</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>George I. Smith Jr.</u>   |  |  |  | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>27 MAY 82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. George I. Smith, Jr., MD.   |  |  |  | 22e. ADDRESS<br>804 Toll House Ave., Frederick, Md. 21701   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>May 29, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Rocky Springs Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Frederick, Frederick, Md.  |  |
| 24. FUNERAL DIRECTOR<br><u>Smith, Keeney and Basford Funeral Home</u><br>106 East Church St., Frederick, Md. 21701   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 3 1982   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Theresa J. [Signature]</u>  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 2 1 2 9 9 3  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  |   |  |
| Isabell Edna MAY  |  |  |  | May 19, 1982   |  |   |  |
| 3 SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                   |  |
| Female  |  | White  |  | July 14, 1898  |  | 83 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                              |  |
| West Va.  |  | U.S.A.   |  |  |  | Frederick County, MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                 |  |
| Frederick   |  | Frederick Memorial Hospital  |  | Seamstress   |  | Clothing Co   |  |
| 13a. STATE  |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  |
| Maryland  |  |  |  | Frederick  |  | Frederick   |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |
| James Weese   |  |  |  | Eva Jane Philips   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  |
| no  |  |  |  | 220-18-1052  |  | Mr. James A. Glover, 322 Braddock Ave., Frederick, Maryland 21701 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>   |  |  |  |  |  |   |  |
| 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery disease</i>  |  |  |  |  |  |   | 15 years                                     |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?    |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
|   |  | P.M. 19  |  |  |  |   |  |
| 21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |   |  |
|   |  |  |  | CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>March</i> 19 <i>52</i> , to <i>May</i> 19 <i>82</i> , that (I) <del>was</del> last saw the deceased alive on <i>May 9</i> 19 <i>82</i> , and that in (my) <del>an</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> did not view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |  | 22c. DATE SIGNED  |  |
| <i>Bernard O. Thomas Jr</i>   |  |  |  | <i>MD</i>  |  | <i>5/21/82</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |   |  |
| Dr. Bernard O. Thomas M.D.  |  |  |  | 228 North Market Street, Fred. Md.   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |
| Burial  |  | May 21, 1982   |  | Mt. Olivet Cem.  |  | Frederick Frederick Md.   |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. DATE AND TIME OF REGISTRATION   |  |   |  |
| Smith Keeney Basford C.A. Funeral Home  |  |  |  | MAY 25 1982  |  |   |  |
| 106 E. Church St., Frederick, Md. 21701   |  |  |  |  |  |   |  |

BP

8 2 1 5 0 0 0

May 12, 1902

ANY

Anna

Isabel

13

July 11, 1902

White

Female

Frederick County,

X

U.S.A.

West Va.

Frederick Memorial Hospital

Frederick Memorial Hospital

Frederick

802 E. Patrick Street

X

Frederick Frederick

Frederick

William

James

Wm

Wm

James

Mr. James A. Oliver, 322 Broadway  
Frederick, Maryland, 21701

320-15-1022 Ave., Frederick, Md. 21701

no

X

228 North Market Street, Fred. Md.

Dr. Bernard G. Thomas M.D.

Frederick Frederick

Frederick Frederick

100 E. Church St., Frederick, Md. 21701

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| 1- FOR<br>STATE<br>REGISTRAR  |  | 8 2 1 2 9 9 4<br>CERTIFICATE OF DEATH<br>REG. NO.   |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Emma Rosina Meekins</i>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>5 11 82</i>   |  | 2b. HOUR<br><i>5:30 AM</i>  |  |
| 3. SEX<br><i>F</i>  |  | 4. RACE<br><i>W.</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>6 17 1906</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>75</i> YRS.   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><i>10 24</i>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Frederick Co., MD.</i>   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Frederick</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Frederick Memorial Hospital</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><i>Maryland</i>   |  |   |  |   |  | 13c. CITY OR TOWN<br><i>Mt. Airy</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Ferdinand Wise</i>   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Elsie Mae Tucker</i>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>217-10-8651</i>  |  | 17. INFORMANT<br>ADDRESS<br><i>Mt. Airy, Md.<br/>Marvis L. Grimes, 5556 Buffalo Rd.</i>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Sudden myo. infarction</i><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Cranial Artery disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>5 days</i><br><i>6 years</i> |  |   |  |   |  |   |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>0</i> |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/8</i> , 19 <i>80</i> , to <i>5/10/</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>5/10/</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death, <i>8/8</i> )  |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Robert L. Thompson</i>   |  |   |  |   |  | 22c. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22d. DATE SIGNED<br><i>5/11/82</i>  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  |   |  | 22f. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>5-13-1982</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Locust Grove</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Frederick, Md.</i>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Charles W. Burrier, Jr., Sykesville, Md.</i>   |  |   |  |   |  | 25. DATE REC'D. BY REGISTRAR<br><i>MAY 14 1982</i>  |  | 26. REGISTRAR'S SIGNATURE<br><i>Anna J. [Signature]</i>   |  |

BP \_\_\_\_\_

1. Name of the plant: *...*  
2. Locality: *...*  
3. Date of collection: *...*  
4. Collector: *...*  
5. Number of specimens: *...*  
6. Description of the plant: *...*  
7. Remarks: *...*

8. Date of analysis: *...*  
9. Analyst: *...*  
10. Signature: *...*  
11. Date of report: *...*  
12. Remarks: *...*



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 1 2 9 9 5

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |   |   |  |   |  |   |  |
|--|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELSIE Mabel Mengel</b>        |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>5 6 82</b> |   |  | 2b. HOUR<br><b>11: PM</b>   |  |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 30 1907</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>PA.</b>           |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Fred Co.</b> MD.                                     |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>MT. AIRY</b>                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>18 Lexington Dr.</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |  |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>Fredrick</b>   |   | 13c. CITY OR TOWN<br><b>MT. AIRY</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>18 Lexington Dr.</b>                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Mabel Mengel</b> |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Amanda Fisher</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |   |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>202-24-5235</b>                       |  | 17. INFORMANT ADDRESS<br><b>Charles Arlan Mengel, Box 41 Monrovia Md.</b>  |   |   |  |   |  |   |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CEREBRO VASCULAR ACCIDENT</b><br>(c) <b>ATHEROSCLEROTIC CEREBROVASCULAR DISEASE</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|---|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-6</b> , 19 <b>82</b> , to <b>5-6</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>5-6</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |  |  | DEGREE<br><b>ATTENDING PHYSICIAN</b>   |  | 22c. DATE SIGNED<br><b>5-6-82</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ARTHUR G. MARSHALL, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>GREEN VALLEY, MONROVIA, MD 21770</b>                              |  |  |  |

|  |  |                            |  |   |  |  |  |
|--|--|----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>cremate</b>                 |  | 23b. DATE<br><b>5/7/82</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlexton Arlexton VA.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>W. C. Helt Bernsville Rd. 20838</b> |  |                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 12 1982</b>       |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |   |                           |  |  |
|--|--|--|--|--|--|---|---------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  | 8 2 1 2 9 9 6                                |   |                           |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR             |   |                           |  |  |
| Agnes Elizabeth MERCER   |  |  |  |  | May 1, 1982                                  |   |                           |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |                           | 7b. HOUR   |  |
| Female   |  | White  |  | October 11, 1897   |  | 84 YRS  |                           | 11:45 A M  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                           |  |  |
| Maryland   |  | USA  |  |  |  | Frederick County MD.  |                           |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |   |                           |  |  |
| Braddock Heights   |  | Vindobona Nursing Home   |  |  |  |   |                           |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |   |                           |  |  |
| Cafeteria worker   |  | Elem. School   |  |  |  |   |                           |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |                           | 13e. STREET ADDRESS  |  |
| Maryland   |  | Frederick  |  | Frederick  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                           | 240 East 7th Street  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |   |                           |  |  |
| Lewis Samuel Ridgely   |  |  |  |  | Minerva Mae Kolb                             |   |                           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |  |  |  | 16b. SOCIAL SECURITY NO.                     |   | 17. INFORMANT             |  |  |
| NO   |  |  |  |  | 217-16-2166                                  |   | Mrs. Annabelle V. Lemhart |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |                           |  |  |
| IMMEDIATE CAUSE (a) <u>pneumonia</u>   |  |  |  |  | 3 days                                       |   |                           |  |  |
| 4280 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cong. Heart Failure</u>   |  |  |  |  | 5 years                                      |   |                           |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |   |                           |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |  |  |   |                           |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                           | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |                           |  |  |
|  |  | P.M. 19  |  |  |  |   |                           |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET   |  | CITY OR TOWN  |                           | COUNTY STATE   |  |
|  |  |  |  |  |  |   |                           |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1978</u> to <u>5/1</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>4/20</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |                           |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |                           |  |  |
|  |  |  |  | 4/3/82   |  |   |                           |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  | 22e. ADDRESS                                 |   |                           |  |  |
| Dr. Robert L. Kauffman, M. D.  |  |  |  |  | 804 Toll House Road Frederick, MD 21701      |   |                           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |                           |  |  |
| Burial   |  | May 4, 1982  |  | Mount Olivet Cemetery  |  | Frederick, Frederick, MD  |                           |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                       |                           |  |  |
| Smith, Keeney and Basford  |  |  |  |  |  | MAY 6 1982  |                           |  |  |
| 106 East Church St. Frederick, MD 21701  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |                           |  |  |

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DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 1 2 9 9 7

REG. NO.

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Catherine Craigmile MICHAEL   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 11, 1982                           |  | 2b. HOUR<br>4:50 P.M.   |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 11, 1902  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County, MD   |   |
| 10. CITY OR TOWN OF DEATH<br>Frederick   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home                       |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>Frederick  | 13c. CITY OR TOWN<br>Frederick   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William E. Craigmile   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary E. Elder                |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>None  |   | 17. INFORMANT<br>Russell L. Michael, 107 East Church Street, Frederick, Md. 21701                    |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ruptured thoracic aortic aneurysm 5 mm<br>4411<br>DUE TO, OR AS A CONSEQUENCE OF (b) ASD<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |   |   |  |   |
| 19a. DATE OF OPERATION<br>May 10, 1982   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>subdural hematoma   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 5/9 82  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>fell + struck head |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>0   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>74 5/4 82                                       |   |
| 22a. I certify that (I) (this hospital) attended the deceased from July 19 74 to 5/4 19 82, that (I) (we) last saw the deceased alive on July 19 74, and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above.   |  |   |   |  |   |
| 22b. SIGNATURE<br>Timothy Hickey   |  |   |   | 22c. DATE SIGNED<br>5/12/82  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Timothy Hickey, Jr., M.D.   |  |   |   | 22e. ADDRESS<br>Parkview Medical Center, Frederick, Md.  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>May 13, 1982   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Smithsburg Crematory   |   |
| 23d. LOCATION<br>(CITY OR TOWN COUNTY STATE)<br>Smithsburg, Washington, Md.  |  | 24. FUNERAL DIRECTOR<br>Smith, Keeney and Basford Funeral Home<br>106 East Church St., Frederick, Md. 21701   |   |  |   |
| 25. DATE RECD BY REGISTRAR<br>MAY 14 1982  |  |   |   | 26. REGISTRAR'S SIGNATURE  |   |

1-24-77

85

THE UNIVERSITY OF MICHIGAN  
ANN ARBOR, MICHIGAN 48106-1000

May 11, 1962

Mr. J. H. ...

May 11, 1962

Dear Sir:

Enclosed

Enclosed

Enclosed

Enclosed

Enclosed

Enclosed

Enclosed

Enclosed

Enclosed

Enclosed

Enclosed

Enclosed

Enclosed

Enclosed

Enclosed

Enclosed

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Enclosed



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |   |  |  |
|---|--|---|--|---|--|--|---|--|--|
| <div style="text-align: right;">8 2 1 2 9 9 8</div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b><br/>           REG. NO.         </div>  |  |   |  |   |  |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Edgar Leo Miller</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 10, 1982</b>         |  |   | 2b. HOUR<br><b>5:12 PM</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>September 28, 1920</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b><br>YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 74 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick</b> MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Postal Worker</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Postal</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Frederick</b>   |  | 13c. CITY OR TOWN<br><b>Thurmont</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>13227 Cactoctin Furnace Road</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Everett Miller</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Brown</b> |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN)<br><b>yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF KNOWN, GIVE YEAR OR DATES)<br><b>WW II 213-18-8562</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Lelia M. Miller 13227 Cactoctin Furn. Rd. Thurmont, Md. 21788</b>  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>coronary thrombosis</u><br>2500 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetic Mellitus</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |   |  |   |  |  |   |  |  |
| MEDICAL CERTIFICATION   |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>1965</u> , 19____, to <u>5/10/82</u> , 19____, that (1) (we) last saw the deceased alive on <u>5/7/82</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><i>George Morningstar</i>   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>5/11/82</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George Morningstar, MD</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>South Seton Ave. Emmitsburg, Maryland 21727</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>May 13, 1982</b>                                       |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Resthaven Cemetery</b>    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick Frederick Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Robert E. Dailey &amp; Son 615 E. Main Thurmont, Md</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 17 1982</b>  |   |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |  |  |  |   |   |   |
|--|--|--|---|--|--|--|---|---|---|
| 1. FOR STATE REGISTRAR   |  |  |   |  | 7 2 1 2 9 9 9  |  |   |   |   |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |   |   |
| Nelson W. MYERS, Sr.   |  |  |   |  | May 15, 1982   |  |   |   |   |
| 3. SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | 2b. HOUR  |   |
| Male   |  | White  |   | Feb. 8, 1899   |  | 83 YRS   |   | 4:35 P.M.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                   |   |   |   |
| Maryland   |  | USA  |   |  |  | Frederick Co., MD.   |   |   |   |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)          |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| Frederick  |  | Frederick Memorial Hospital  |   |  |  | Carpenter  |   |   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |  | 13d. INSIDE CITY LIMITS?   |  |   |   |   |
| 13a. STATE Maryland 13b. COUNTY Frederick 13c. CITY OR TOWN Ijamsville   |  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lewis Myers  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Walker  |  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  |  |   |  | 16b. SOCIAL SECURITY NO. 216-14-5282   |  | 17. INFORMANT ADDRESS 4732 Mussetter Rd. Ijamsville, Md.                  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>4409 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Advanced generalized Atherosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>20 years</u>                              |  |  |   |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Within minutes</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |  |   |   |   |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>5-15</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>12-1-</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |  |   |  |  |  |   |   |   |
| 22b. SIGNATURE <u>Ralph L. Michels</u> DEGREE <u>M.D.</u>  |  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED May 16, 1982   |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Ralph L. Michels, M.D.</u>  |  |  |   |  | 22e. ADDRESS <u>Frederick Medical Center, Frederick, Md.</u>   |  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |  |  | 23b. DATE <u>May 18, 1982</u>                                       |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Ijamsville Meth.</u>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Ijamsville, Frederick, Md.</u> |   |   |
| 24. FUNERAL DIRECTOR <u>Orin L. Molesworth, P.A.,</u> ADDRESS <u>Danascus, Md.</u>   |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <u>MAY 15 1982</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Thom...</u>                                 |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at a

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2. DATE OF DEATH   |  |   |  | 3. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2. DATE OF DEATH   |  |   |  | 3. HOUR  |  |
| GALLY PEARL MYERS  |  |  |  | 5/17/82  |  |   |  | 7:40 M   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR   |  |
| Female   |  | White  |  | December 6, 1898.  |  | 83 YRS.   |  | IF UNDER 24 HRS  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |
| Maryland   |  | USA  |  |  |  | Frederick County  |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| Frederick  |  | Frederick Memorial Hospital  |  | Housewife  |  | Home  |  |  |  |
| 13a. STATE   |  |  |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS  |  |
| Maryland   |  |  |  | Frederick  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 202 Grove Blvd. 21701  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |
| C. Grant Delphey   |  |  |  | Laura Hildebrand   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 16c. ADDRESS  |  |  |  |
| NO   |  |  |  | 219-66-3323  |  | 202 Grove Blvd. Frederick, MD 21701                                 |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of the uterus</u>  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>   |  |
| 1790   |  |  |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED   |  |   |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  | ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2  |  |   |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  |   |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET   |  | CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Apr. 15</u> , 19 <u>81</u> , to <u>May 17</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>May 17</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  |   |  | 22c. DATE SIGNED   |  |
| <u>Henry V. Chase</u>  |  |  |  | MD   |  |   |  | May 12, 1982   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |   |  |  |  |
| Henry V. Chase   |  |  |  | MD. 804 Toll House Ave Frederick MD  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | 23e. STATE   |  |
| Burial   |  | May 20, 1982   |  | Mount Olivet Cemetery  |  | Frederick, Frederick, MD  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. DATE RECD. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Smith, Keeney and Basford  |  |  |  | 106 East Church St. Frederick, MD 21701  |  | MAY 20 1982   |  | <u>Frances Jean Nathan</u>                                     |  |

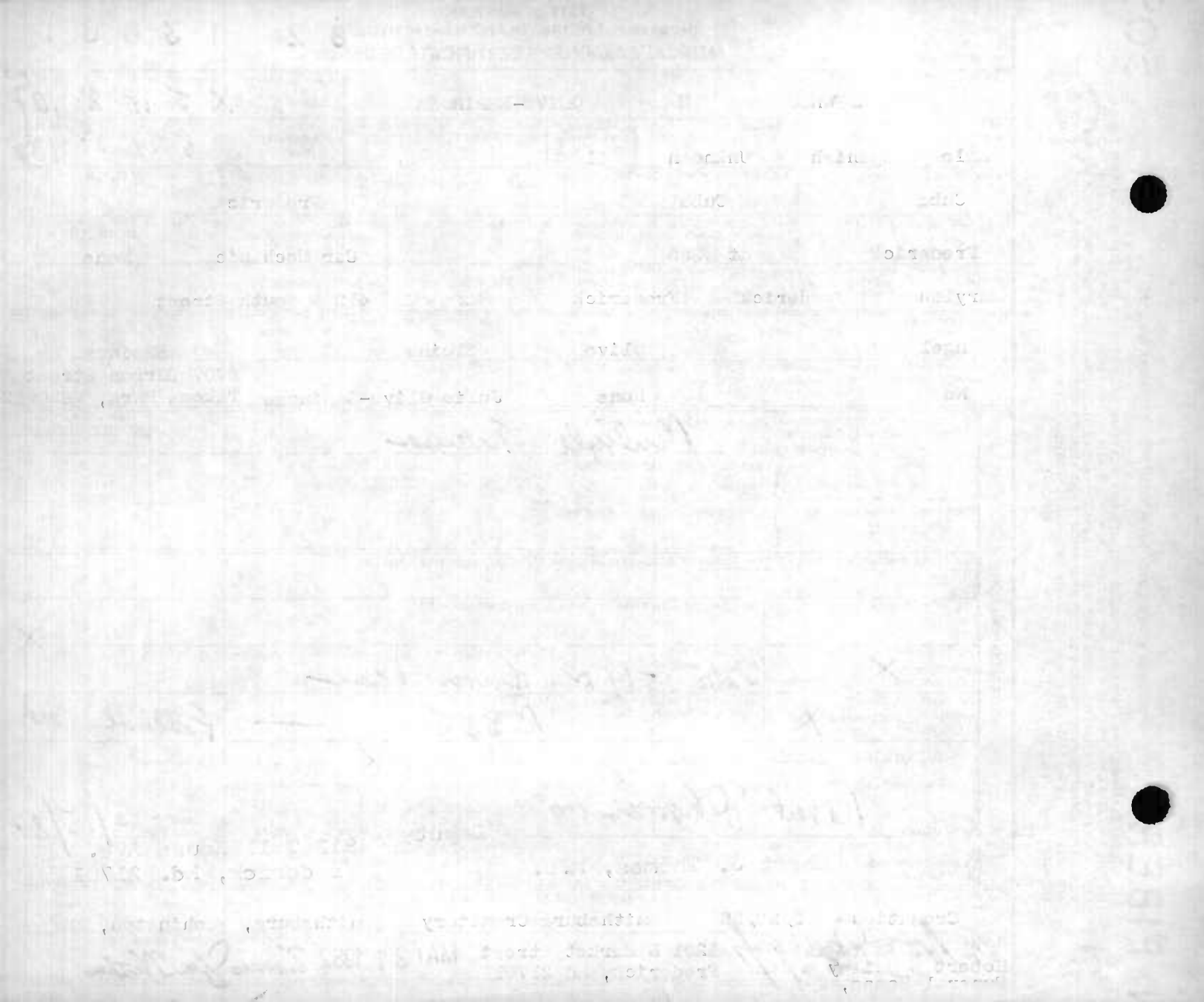
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS OF BURIAL, CREMATION, OR REMOVAL. TO STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS: 301 W. PRESIDENT STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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| 1- STATE REGISTRAR  |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  | 8 2 1 3 0 0 1                                  |  |
| 1. DECEASED NAME (TYPE OR PRINT)                          |  | 20. DATE KNOWN OF DEATH   |  | 2b. HOME                                       |  |
| ALFONSO   |  | X 5 14 82   |  | 10P  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH                               |  |
| Male  |  | Spanish   |  | Unknown  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                 |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED                                     |  |
| Cuba  |  | Cuba  |  | NEVER MARRIED X                                |  |
| 10. CITY OR TOWN OF DEATH                                 |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION                            |  | 12a. USUAL OCCUPATION                          |  |
| Frederick   |  | Rt #355   |  | Car Mechanic                                   |  |
| 13a. STATE  |  | 13b. CITY OR TOWN   |  | 13c. STREET ADDRESS                            |  |
| Maryland  |  | Frederick   |  | 412 W South Street                             |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  | 16. SOCIAL SECURITY NO.                        |  |
| Angel   |  | Eloina  |  | None   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?              |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT                                  |  |
| No  |  | None  |  | Julio Olive-Espinosa                           |  |
| 18. CAUSE OF DEATH  |  | 19. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                    |  | 20. AUTOPSY?                                   |  |
| Multiple Trauma   |  |   |  | YES X NO                                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH |  | 21a. EXTERNAL CAUSE WAS   |  | 21b. TIME OF INJURY                            |  |
|   |  | UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 2205 5/14/82                                   |  |
|   |  | 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY                           |  |
|   |  | WHILE AT WORK X   |  | Rt 355   |  |
|   |  | 21f. LOCATION   |  | Frederick Md                                   |  |
|   |  | 22a. I certify that I took charge of the remains described above, held on           |  | Autopsy X Inspection Inquiry and in my opinion |  |
|   |  | death resulted from: Natural causes X Accident Suicide Homicide Undetermined manner |  |  |  |
| ACTUAL SIGNATURE  |  | TITLE (SPECIFY)   |  | DATE SIGNED                                    |  |
| Robert J. Thomas, M.D.                                    |  | Deputy  |  | 5/15/82  |  |
| EXAMINER'S NAME   |  | ADDRESS   |  | MEDICAL EXAMINER                               |  |
| Robert J. Thomas, M.D.                                    |  | Frederick, Md. 21701  |  | 812 Toll House Ave.                            |  |
| 23a. BURIAL, CREMATION, REMOVAL                           |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY             |  |
| Cremation   |  | 5/20/82   |  | Smithsburg Crematory                           |  |
| 24. FUNERAL HOME  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                     |  |
| Robert E. Dalley & Son                                    |  | MAY 21 1982   |  | Francis J. Nathan                              |  |
| Funeral Homes, P.A.                                       |  | 1201 N Market Street  |  | Frederick, Md 21701                            |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (1))  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>Alicia<br>XXXX   |  | MIDDLE<br>Francisco   |  | LAST<br>Patterson   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>5 27 1982  |  | 2b. HOUR<br>3:52  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Philippine   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 17, 1946   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>35 YRS.   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>5 27 1982 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Philippines   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County, MD.                                   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Teacher                        |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>School                                  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |  |  |  |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Frederick  |  | 13c. CITY OR TOWN<br>Walkersville   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>8604 Discovery Blvd. 21793  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Remegio Francisco  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>-- -- -- Damian  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-- -- --   |  | 17. INFORMANT<br>8604 Discovery Blvd. Walkersville, MD<br>John L. Patterson 21793               |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Abdominal trauma</u><br>8419<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>1:50 P.M. 5 27 1982  |  |   |  | 21b. TIME OF INJURY<br>HOUR XX MONTH DAY YEAR<br>1:50 P.M. 5 27 1982  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)<br>Driver in auto/plane impact |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>road   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Highway 15 Frederick Frederick Md                       |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |  |   |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>   |  |   |  | TITLE (SPECIFY)<br>M.D. Deputy Chief  |  |   |  | DATE SIGNED<br>5/28/82   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.   |  |   |  | ADDRESS<br>111 Penn ST. Balto. Md.  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   |  | 23b. DATE<br>June 1, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Olivet Cemetery                                     |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Frederick, Frederick, Maryland |   |  |
| 24. FUNERAL DIRECTOR<br>Smith, Keeney & Basford  |  |   |  | ADDRESS<br>106 East Church St. Frederick, MD 21701  |  |   |  | 25. DATE REC'D. BY REGISTRAR<br>JUN 3 1982   |  | 25. REGISTRAR'S SIGNATURE<br><i>Thomas D. Smith</i>     |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 3 0 0 3  
CERTIFICATE OF DEATH

|   |  |   |  |
|---|--|---|--|
| FOR<br>1. STATE<br>REGISTRAR  |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |  |
| FIRST MIDDLE LAST<br><i>Patsy ANN PERRY</i>   |  | MONTH DAY YEAR<br><i>5 29 82</i>  |  |
| 3. SEX  |  | 4. RACE   |  |
| Female  |  | White   |  |
| 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
| MONTH DAY YEAR<br><i>Jan. 21, 1951</i>  |  | YRS MONTHS DAYS HOURS MIN<br><i>31</i>  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| Maryland  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Frederick Co., MD</i>  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  |
| Frederick   |  | Frederick Memorial Hospital   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Housewife   |  |   |  |
| 13a. STATE  |  | 13b. COUNTY   |  |
| Maryland  |  | Carroll   |  |
| 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| Union Bridge  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |
| FIRST MIDDLE LAST<br><i>Ray Naill</i>   |  | FIRST MIDDLE LAST<br><i>Dorothy Alger</i>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.  |  |
| No  |  | 215-48-8975   |  |
| 17. INFORMANT   |  | ADDRESS   |  |
| Larry E. Perry,   |  | Item 13   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Respiratory arrest</i><br><i>2600</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>histiocytic lymphoma</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>CONDITIONS, IF ANY, WHICH<br>GAVE RISE TO IMMEDIATE<br>CAUSE (a), STATING THE<br>UNDERLYING CAUSE LAST. |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>6 yrs</i>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>cord compression C 6-7</i>  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
|   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 20d. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                               |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1980</i> , 19 <i>5/28</i> , to <i>5/28</i> , 19 <i>82</i> , that (I) (we) lost<br>saw the deceased alive on <i>5/28</i> , 19 <i>82</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                          |  |   |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED  |  |
| <i>[Signature]</i>  |  | <i>5/28/82</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  |
| <i>DR. D. Roush</i>   |  | <i>4 West Seneca, Frederick, Md.</i>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  |
| Burial  |  | May 31, 1982  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| Pine Grove  |  | Mt. Airy, Carroll, Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  |
| Clin L. Molesworth, P.A., Damascus, Md.   |  | JUN 3 1982  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |   |   |   |  |   |   |  | 8 2 1 3 0 0 4                                   |  |
|--|--|---|---|---|---|--|---|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | CERTIFICATE OF DEATH  |   |   |   |  |   |   |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Glenn Layton Phares</b>  |  |   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>MAY 20 82</b>                                     |  |   | 2b. HOUR<br><b>9:34 AM</b>  |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 23, 1901</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>80</b>   |  | IF UNDER 24 HRS<br>HOURS MIN.<br><b>9:34</b>    |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Indiana</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County, MD.</b>                 |   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b>  |   | 12b. KIND OF BUSINESS OR<br>Company<br><b>Cash Register</b>   |  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY<br><b>Frederick</b>   |   | 13c. CITY OR TOWN<br><b>Frederick</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>2760 Lynn Street</b> |   |  |
| 14. FATHER'S NAME<br>MIDDLE LAST<br><b>Willard M. Phares</b>   |  |   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Wissing</b>                        |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>None</b>              |   | 17. INFORMANT<br>ADDRESS<br><b>2760 Lynn Street</b>   |  | <b>Mrs. Nancy Jill Sheedy, Frederick, Md. 21701</b>   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Emphysema</b><br><b>4920</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |   |   |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>NA</b>   |  |   |   |   |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>NA</b>  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>NA</b>                       |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>PM 19</b>                     |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>NA</b> |  |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>AM</b> |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>MM</b>                              |  |   |   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>April 30, 1982</b> , to <b>May 20, 1982</b> , that (I) (we) last saw the deceased alive on <b>May 19, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                   |  |   |   |   |   |  |   |   |  |   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lloyd A. Alcorn</b>  |  |   |   |   | 22c. ADDRESS<br><b>198 Hume Johnson Rd Frederick, Md.</b>                                   |  |   | 22d. DATE SIGNED<br><b>5/20/82</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>May 23, 1982</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Resthaven Memorial Gardens</b>                     |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick, Md.</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Smith, Keeney and Basford Funeral Home</b><br><b>106 East Church St., Frederick, Md. 21701</b>  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 25 1982</b>   |  |   |   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 2 1 3 0 0 5   |  |
|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH   |  |
| George Croghan REID   |  |  |  | May 1, 1982   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |
| Male  |  | White  |  | January 15, 1910  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| Washington, D.C.  |  | USA  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |
| Frederick   |  | Citizens Nursing Home  |  | Draftsman   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  |
| Maryland  |  | Frederick  |  | Urbana  |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)   |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)   |  | 13d. STREET ADDRESS   |  |
| George Conrad Reid  |  | Alice Hyatt  |  | 3543 Urbana Pike 21701  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |  |
| NO  |  | 578-12-1674  |  | 3543 Urbana Pike<br>Mrs. Bessie C. Reid Frederick, MD 21701   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>4392<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Ventricular fibrillation</u><br>(c) <u>Atherosclerotic C.V.D.</u>   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Organic brain syndrome</u>   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 2</u> , 19 <u>82</u> , to <u>May 1</u> , 19 <u>82</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>April 30</u> , 19 <u>82</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED  |  |
| <u>B. O. Thomas, Jr.</u>  |  | M.D.   |  | 5/3/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |  |
| Dr. B. O. Thomas, Jr., M. D.  |  | North Market St. Frederick, Maryland 21701   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Burial  |  | May 4, 1982  |  | Fort Lincoln Cemetery   |  |
| 24. FUNERAL DIRECTOR  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  | 23e. DATE REC'D. BY REGISTRAR   |  |
| Smith, Keeney & Basford   |  | Bladensburg, Pr. Georges, MD   |  | 6/1982  |  |
| 106 East Church St. Frederick, MD 21701   |  | 24a. REGISTRAR'S SIGNATURE   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies; Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of office.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |   |
|--|--|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARIE RENN REMSBERG</b>   |  | 2a. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>31</b> YEAR <b>82</b>   |  | 2b. HOUR<br><b>3:40</b> P.M.   |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>Dec.</b> DAY <b>8</b> YEAR <b>1896</b>                  |   |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |  | 8. IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>                                    |   |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick Co.</b> MD.                     |   |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b>  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  | 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Fred.</b>  |   |
| 13c. CITY OR TOWN<br><b>Middletown</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>100 Larch Lane</b>   |   |
| 14. FATHER'S NAME<br>FIRST <b>CHARLES</b> MIDDLE <b>C.</b> LAST <b>RENN</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ANNIE</b> MIDDLE <b></b> LAST <b>KEEFER</b>   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-74-6085</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Frank Remsberg Middletown, Md.</b>                    |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>AS I.D.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>4100</b> |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Dilated cardiomyopathy</b>   |  |  |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                         |   |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)               |   |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (1) (this hospital) attended the deceased from <b>May 28</b> , 19 <b>82</b> , to <b>May 31</b> , 19 <b>82</b> , that (1) (we) lost saw the deceased on <b>May 31</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><b>WJ Reddick</b>  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>6/1/82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Willis J. Reddick</b>  |  | 22e. ADDRESS<br><b>Frederick, Md.</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>June 3, 1982</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Reformed Cem.</b>                           |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Middletown Fred. Md.</b>  |  | 24. FUNERAL DIRECTOR<br>NAME <b>Thompson Funeral Home</b> ADDRESS <b>Middletown, Md.</b>   |  |  |   |
| 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE<br><b>W. J. Reddick</b>   |  |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  | 8 2 1 3 0 0 7  |  |  |  |
|---|--|---|--|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |  |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Clyde McKinley Roney</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>5-6-82</b>  |  |   |  | 2b. HOUR<br><b>8<sup>10</sup> PM</b>   |  |  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>7 29 97</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | 8. IF UNDER 24 HRS.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick County, MD.</b>                               |  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Auto Dealer</b>          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>- - - - -</b>  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b>  |  |   |  | 13b. COUNTY <b>Frederick</b>  |  | 13c. CITY OR TOWN <b>Frederick</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>903 Rosemont Avenue</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John H. Roney</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Florence Barnes</b>   |  |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>WW 1, II 220-18-1283</b>   |  | 17. INFORMANT ADDRESS<br><b>Mrs. Olga O. Roney, 903 Rosemont Avenue, Frederick, Maryland 21701</b> |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vasc. Disaster</b><br><b>4360</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Cerebral Vasc. Disaster</b><br>(c) <b>2 years</b> |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>14 hours</b>  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>   |  |   |  |   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                     |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/6/82</b> to <b>5/11/82</b> , that (I) (we) last saw the deceased alive on <b>5/6/82</b> , and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, so state.)          |  |   |  |   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Robert L. Kaufmann, M.D.</b>   |  |   |  |   |  | 22c. DATE SIGNED<br><b>5/7/82</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Robert L. Kaufmann M.D.</b>                     |  |  |  |  |  |
| 22e. ADDRESS<br><b>804 Toll House Ave., Fred. Md. 21701</b>   |  |   |  |   |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   |  | 23b. DATE<br><b>May 10, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cem.</b>                                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick Frederick Md.</b>                    |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Smith Keeney Hasford P.A. Funeral Home</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 11 1982</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James G. [Signature]</b>                                       |  |  |  |  |  |
| 106 E. Church St., Frederick, Md. 21701   |  |   |  |   |  |  |  |   |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |   |   |   |  |  |
|---|--|--|--|--|---|---|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 7 2 1 3 0 0 8   |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  | 2a. DATE OF DEATH   |   |   |  |  |
| MAZEL Katherine RUNKLES   |  |  |  |  | 5 6 82 11:50 AM   |   |   |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |   | 7. IF UNDER 1 YEAR   |  |
| Female  |  | White  |  | March 12, 1906   |   | 76  |   | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |  |  |
| Brunswick, Md.  |  | U. S. A.   |  |  |   | Frederick MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Frederick   |  | Frederick Memorial Hospital  |  |  |   | Housewife   |   | Own Home   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?  |   | 13e. STREET ADDRESS  |  |
| Maryland  |  | Frederick  |  | Brunswick  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 408 9th Ave.   |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME  |   |   |  |  |
| FIRST MIDDLE LAST<br>Jacob Henry Moler  |  |  |  |  | FIRST MIDDLE LAST<br>Laura Virginia Smith   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |  |  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT   |  |  |
| No  |  |  |  |  | 215-44-9209   |   | 408 9th Ave.<br>Joanne M. Runkles, Brunswick, Md. 21716 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive heart failure  |  |  |  |  |   |   |   |  | 2-3 days                                     |
| 4280<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost   |  |  |  |  |   |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |  |  |  |   |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |  |   |   |   |  |  |
| Renal failure, hemiplegia 2° to CVA   |  |  |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  |   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |   |   |  |  |
|   |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |   |   |   |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |   |   |   |  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |  |
| 22a. I certify that (1) this hospital attended the deceased from 19 74 to 5/6 82, that (2) (we) lost saw the deceased alive on 5/5 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) did not view the body after death. |  |  |  |  |   |   |   |  |  |
| 22b. SIGNATURE  |  |  |  |  | DEGREE  |   |   | 22c. DATE SIGNED   |  |
| C. Allgauer   |  |  |  |  | M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 5/6/82   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  | 22e. ADDRESS  |   |   |  |  |
| WAYNE ALLGAUER  |  |  |  |  | BRUNSWICK MD. 21716   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION   |   |  |  |
| Burial  |  | 5-8-82   |  | Brownsville Hgts. Cem.   |   | Brownsville, Wash. Co., Md.   |   |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE                              |  |  |
| NAME John H. Bast, Jr. ADDRESS Boonsboro, Md. 21713   |  |  |  |  | MAY 10 1982   |   |   |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 77 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 3 0 0 9  
CERTIFICATE OF DEATH

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | MONTH DAY YEAR   |   | MONTH DAY YEAR   |  |
| Blanche Cecelia Sanders   |  | May 28 1982  |   | 720 P M  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR  |  |
| Female  | White  | 16 Sept. 1895  | 86 YRS  | IF UNDER 24 HRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |
| Maryland  | U. S. A.   |  | Frederick County MD.  |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Frederick   | Frederick Memorial Hospital  |  | Housewife   |  |  |
| 13a. STATE  | 13b. CITY OR TOWN  | 13c. INSIDE CITY LIMITS?   | 13d. STREET ADDRESS   |  |  |
| Maryland  | Frederick  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | Welly Road, Emmitsburg, Md.   |  |  |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |
| Marshall  | Sprinkle   |  | Butt  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS  |   |  |  |
| No  | 213-74-4405  | Pa. 17325  |   |  |  |
|   |  | Paul Sanders R. D. # 9 Box 208 Gettysburg  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Congestive heart failure  |  |  |   |  | 1 week                                       |
| 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis - Coronary - Vascular Disease   |  |  |   |  | 10 years                                     |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |
| Fracture distal third right femur   |  |  |   |  |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |
|   | HOUR A.M. MONTH DAY YEAR   |  |   |  |  |
|   | P.M. 19  |  |   |  |  |
| 21d. INJURY OCCURRED  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION  |   |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | STREET CITY OR TOWN COUNTY STATE   |   |  |  |
|   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec. 19 79, to May 28 19 82, that (I) (we) last saw the deceased alive on May 28 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |   |  |  |
| 22b. SIGNATURE  |  | DEGREE   | 22c. DATE SIGNED  |  |  |
| Bernard O. Thomas, Jr.  |  | M.D.   | 5/29/82   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |   |  |  |
| Bernard O. Thomas, Jr.  |  | 225 N. Market St. Frederick, Md. 21701   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION  |  |
| Burial  | 31 May 1982  | New St. Joseph's   |   | Emmitsburg Frederick Md.                                       |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE                                     |  |
| NAME ADDRESS  |  | JUN 3 1982   |   | [Signature]  |  |
| Skiles Funeral Home Emmitsburg, Md.   |  |  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

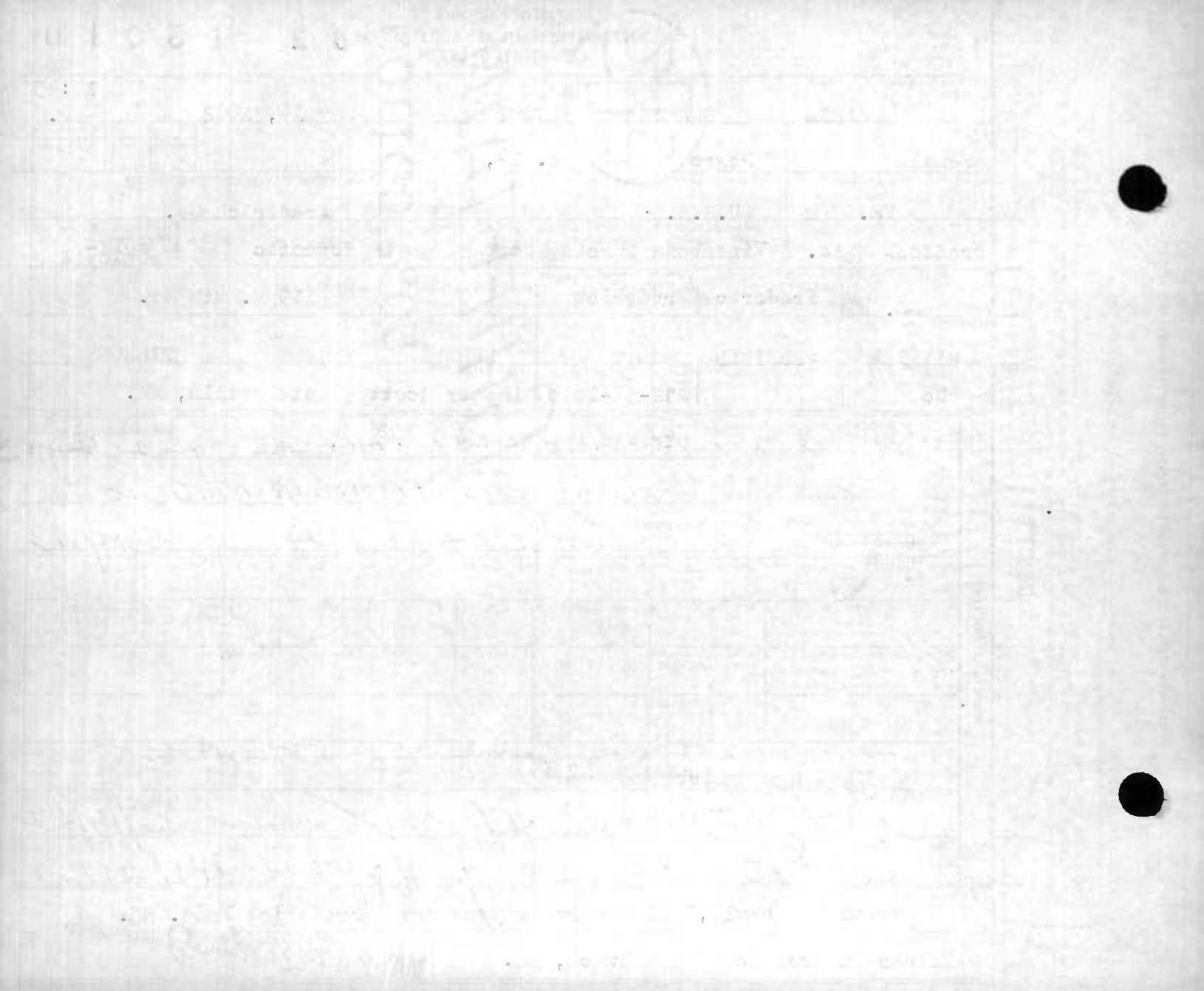
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |   |   |   |  |
|---|--|---|--|---|--|--|---|---|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  |   | 8 2 1 3 0 1 0<br>CERTIFICATE OF DEATH                                  |  |   |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MAMIE BLANCHE SCOTT   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR HOUR<br>May 14, 1982 P. M.            |  |   |   |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Negro  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 14, 1895   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick Co. MD.                      |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Braddock Hgts.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Vindabona Nursing Home |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>domestic   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>self-employed  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  |   |  |   | 13b. COUNTY<br>Frederick   |  | 13c. CITY OR TOWN<br>Frederick  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM WINFIELD SCOTT  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARTHA ANN TIMMONS    |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-32-1618 |  | 17. INFORMANT<br>ADDRESS<br>Lester Scott Petersville, Md.             |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u><br>4360<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Pneumonia</u><br>(c) <u>Secondary to C.I.A.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 Days<br>10 Days<br>24 yrs |  |   |  |   |  |  |   | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 10 55</u> to <u>May 14 1982</u> , that (I) (we) last saw the deceased alive on <u>May 10 1982</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |   |   |   |  |
| 22b. SIGNATURE<br>C. P. Bruce M.D.  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN  |   | 22c. DATE SIGNED<br>5/19/82   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>C. P. Bruce  |  |   |  |   |  | 22e. ADDRESS<br>Lester Scott Petersville, Md. 21255                            |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>May 17, 1982  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Fairview Cemetery                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Frederick Fred. Co. Md. |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Williams Funeral Home   |  |   |  |   |  | ADDRESS<br>Brunswick, Md.  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 24 1982  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to see the body.

| STATE OF MARYLAND  |  |   |  |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |  |  |
| 1. FOR STATE REGISTRAR   |  | 8 2 1 3 0 1 1   |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR  |  |
| BERTHA M. SEYMOUR  |  |   |  |  |  |  |  | MAY 4 1982   |  |
| 2. SEX   |  | 3. RACE   |  | 4. DATE OF BIRTH<br>MONTH DAY YEAR   |  | 5. AGE<br>(IN YEARS LAST BIRTHDAY)   |  | 6. IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| F  |  | W   |  | MAY 11 1899  |  | 82   |  |  |  |
| 7. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  | 10. IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| MD   |  | USA   |  |  |  | FREDERICK CO   |  |  |  |
| 11. CITY OR TOWN OF DEATH  |  | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 13a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)  |  | 14. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| FREDERICK  |  | FREDERICK MEMORIAL Hosp   |  | AT HOME  |  |  |  |  |  |
| 15. USUAL RESIDENCE<br>(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 16. CITY OR TOWN  |  | 17. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 18. STREET ADDRESS   |  |  |  |
| MD   |  | Baltimore   |  | NO   |  | 320 Worthington Rd   |  |  |  |
| 19. FATHER'S NAME<br>FIRST MIDDLE LAST   |  | 20. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  | 21. INFORMANT  |  | 22. ADDRESS  |  |  |  |
| HENRY A DOUGHERTY  |  | NORA MAE  |  | FAMILY RECORDS   |  |  |  |  |  |
| 23. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNKNOWN)   |  | 24. SOCIAL SECURITY NO.   |  | 25. IF YES, GIVE WAR OR DATES  |  | 26. IF YES, GIVE WAR OR DATES  |  |  |  |
| NO   |  |   |  |  |  |  |  |  |  |
| 27. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO CATH ARREST</u><br><u>4149</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CORONARY ARTERY DISEASE.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                 |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |  |  |  |  |  |  |
| 28a. DATE OF OPERATION   |  | 28b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 29a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 29b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 29a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 29b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 29c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 30a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 30b. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 30c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 31. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  | 32. SIGNATURE   |  | DEGREE   |  | 33. DATE SIGNED  |  |  |  |
| 34. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 35. ADDRESS   |  | 36. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>           |  | 37. DATE SIGNED  |  |  |  |
| G.M. ALBUERNE MD.  |  | Frederick Mem. Hospital, Fred., Md.   |  |  |  | 5/4/82   |  |  |  |
| 38a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)   |  | 38b. DATE   |  | 38c. NAME OF CEMETERY OR CREMATORY   |  | 38d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |
| Burial   |  | 5-8-82  |  | Dulaney Valley Mem.  |  | Cockeysville   |  | Baltimore  |  |
| 39. FUNERAL DIRECTOR<br>NAME   |  | 40. DATE REC'D. BY REGISTRAR  |  | 41. DATE REC'D. BY REGISTRAR   |  | 42. DATE REC'D. BY REGISTRAR   |  |  |  |
| EVANS FUNERAL CHAPEL   |  | MAY 13 1982   |  |  |  |  |  |  |  |

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |  |   |  | 8 2 1 3 0 1 2  |  |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | CERTIFICATE OF DEATH  |  |  |  |   |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>George Tony Shaffer   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>5/23/82   |  |  |  | 2b. HOUR<br>1:15 PM   |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>10 25 04   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick MD.                          |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Frederick  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Memorial Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Handyman      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Self-Employ  |  |  |  |
| 13a. STATE<br>Maryland  |  |   |  | 13b. COUNTY<br>Frederick  |  | 13c. CITY OR TOWN<br>Frederick   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1421 Taney Av.e   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>George Anthony Shaffer   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Effie Bell Fritz  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  |   |  | 16b. SOCIAL SECURITY NO.<br>219-01-2284   |  | 17. INFORMANT ADDRESS<br>Mrs. Frances Ahalt Mt. Airy                           |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line; (a), (b), and (c) are to be completed.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Chronic obstructive pulmonary disease<br>4960<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 yrs.   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |   |  |  |  |
| Myocardial ischemia   |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from March 1981, to May 23, 1982, that (I) (we) lost the deceased on May 23, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>James E. Crosby M.D.  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>5/23/82   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>James E. Crosby  |  |   |  | 22e. ADDRESS<br>801 Tollhouse, Frederick  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   |  | 23b. DATE<br>5/26/82  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Resthaven Memorial                       |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Frederick, Frederick, Md.                            |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>G. Douglas Stauffer  |  |   |  | 1621 Opossumtown Pk. Frederick, Md.   |  |  |  | JUN 2 1982  |  | 25b. REGISTRAR'S SIGNATURE<br>James E. Crosby  |  |

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Frederick

Robert

National Institute of Neurological Disorders and Stroke

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Dr. E. V. R.

Richard D. Fisher

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• *St. Ignace*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |         |  |   |  |  |  |  |   | REG. NO. 8 2 1 3 0 1 3   |  |
|---|--|---------|--|---|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |         |  |   |  |  |  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  |  |         |  |   |  |  |  |  |   | 2a. DATE KNOWN OF DEATH  |  |
| ANNA MARIE SHERMAN  |  |         |  |   |  |  |  |  |   | ESTIMATED <input checked="" type="checkbox"/> 5 18 1982                          |  |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH (MONTH DAY YEAR)   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                      |  | IF UNDER 1 YR. MONTHS DAYS   |   | 7c. DATE PRONOUNCED DEAD   |  |
| female  |  | White   |  | May 2 1900  |  | 82 YRS.  |  |  |   | 5 18 1982  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |  |
| Wash. D.C.  |  |         |  | U.S.A.  |  |  |  | Frederick  |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   |  |  |
| Frederick   |  |         |  | Frederick Memorial Hospital   |  |  |  | Clerical Supervisor/Railroad   |   |  |  |
| 13a. STATE  |  |         |  |   |  |  |  |  |   | 13b. CITY OR TOWN  |  |
| Maryland  |  |         |  |   |  |  |  |  |   | Frederick  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |         |  |   |  |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                       |  |
| John Aloysius Ash   |  |         |  |   |  |  |  |  |   | Cornelia C. Fowler   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  |         |  | 16b. SOCIAL SECURITY NO.  |  |  |  | 17. INFORMANT ADDRESS  |   |  |  |
| No  |  |         |  | 718 10 6183   |  |  |  | Nephew Laurence J. King Same as #13  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)   |  |         |  |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH                                     |  |
| PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterograde cardiac vascular disease</u>   |  |         |  |   |  |  |  |  |   |  |  |
| 4292 } DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |   |  |  |  |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |         |  |   |  |  |  |  |   |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |   |  |  |  |  |   |  |  |
| (c)   |  |         |  |   |  |  |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |         |  |   |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |  |  |
|   |  |         |  | P.M. 19   |  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |   |  |  |
|   |  |         |  |   |  |  |  |  |   |  |  |
| 22. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |         |  |   |  |  |  |  |   |  |  |
| ACTUAL SIGNATURE <u>Robert J. Thomas</u> TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER   |  |         |  |   |  |  |  |  |   | DATE SIGNED 5/18/82  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Robert J. Thomas, M.D.  |  |         |  |   |  |  |  |  |   | ADDRESS 812 Toll House Ave. Frederick, Md. 21701                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL  |  |         |  | 23b. DATE May 21, 1982  |  | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Montgomery Md. |  |  |
| 24. FUNERAL DIRECTOR DeVol Funeral Home Inc. ADDRESS 2222 Wisc. Ave. NW/Wash DC   |  |         |  |   |  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR MAY 24 1982  |  |
|   |  |         |  |   |  |  |  |  |   | 25b. REGISTRAR'S SIGNATURE <u>James J. Thomas</u>                                |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |   |   |  |   | 8 2 1 3 0 1 4                                   |  |
|---|--|---|--|---|---|---|---|--|---|---|--|
| 1- FOR STATE REGISTRAR  |  |   |  |   |   |   |   |  |   | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOHN HENRY SHOEMAKER</b><br><i>JOHN HENRY SHOEMAKER</i>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5/15/82</b> <i>May 15 1982</i>                        |   | 2b. HOUR<br><b>33</b> <i>4 PM</i>   |  |   |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 4, 1905</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> <i>YES</i>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   | IF UNDER 24 HRS.                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick</b> MD.  |   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret/Brush Company Ox Fiber Brus.</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                     |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Frederick</b>  |   | 13c. CITY OR TOWN<br><b>Frederick</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>427 South Market Street</b> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas F Shoemaker</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Effie Jane Biser</b>                        |   |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>214-10-2281</b>                        |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs John H Shoemaker 427 South Market St Frederick, Maryland</b> |   |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bilateral pneumonia + respi-</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>rotatory failure</b><br>(b) <b>severe C.O.D. P.D. (emphysema)</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Cancer Rt. Lung.</b><br>(c) <b>severe Bullous emphysema</b> |  |   |  |   |   |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>severe Bullous emphysema</b>   |  |   |  |   |   |   |   |  |   |   |  |
| 19a. DATE OF OPERATION<br><b>5/5/82</b>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Rt. thoracotomy, RUL, Bilateral emphysema</b> |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b> P.M.                                    |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                              |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                               |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/2/82</b> 19 <b>5</b> to <b>15/</b> 19 <b>82</b> that (I) (we) lost<br>saw the deceased alive on <b>5/15</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>below: (I) (we) (did) (did not) view the body after death.                                |  |   |  |   |   |   |   |  |   |   |  |
| 22b. SIGNATURE<br><b>N. P. Foris M.D.</b>   |  |   |  |   |   | DEGREE<br><b>M.D.</b>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>5/15/82</b>              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NICHOLAS P. FORIS</b>   |  |   |  |   |   | 22e. ADDRESS<br><b>27 West 7 St Frederick, Md.</b>  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>5/19/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Olivet Cemetery</b>                                 |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick, Frederick, Md</b>  |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>Robert E Dailey &amp; Son</b>  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 21 1982</b>   |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>James Van N...</i>   |   |  |
| 24. FUNERAL HOMES, P A<br><b>Funeral Homes, P A</b>   |  |   |  |   |   | 25a. ADDRESS<br><b>1201 N Market St Frederick, Md</b>   |   |  |   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |   |  |                                    |  |                                      | 8  | 2 | 1  | 3                                 | 0               | 1 | 5 |
|---|--|--|--|--|---|--|------------------------------------|--|--------------------------------------|--|---|--|-----------------------------------|-----------------|---|---|
| 1. FOR STATE REGISTRAR  |  |  |  |  |   |  |                                    |  |                                      | CERTIFICATE OF DEATH   |   |  |                                   |                 |   |   |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  |   |  |                                    |  |                                      | 2a. DATE OF DEATH  |   |  |                                   |                 |   |   |
| NETTIE MARIE SHRINER  |  |  |  |  |   |  |                                    |  |                                      | 5 20 82 5 <sup>25</sup> PM   |   |  |                                   |                 |   |   |
| 3. SEX  |  |  | 4. RACE  |  |   | 5. DATE OF BIRTH   |                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |  |   | IF UNDER 1 YEAR  |                                   | IF UNDER 24 HRS |   |   |
| FEMALE  |  |  | WHITE  |  |   | MONTH 03 DAY 02 YEAR 97  |                                    |  | 85 YRS.                              |  |   | MONTHS   |                                   | DAYS            |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |   |  |                                   |                 |   |   |
| Maryland  |  |  | USA  |  |   |  |                                    |  | Frederick MD.                        |  |   |  |                                   |                 |   |   |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |                                    |  |                                      | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |                 |   |   |
| FREDERICK   |  |  | FREDERICK MEMORIAL HOSP.   |  |   |  |                                    |  |                                      | Technician   |   |  | Medical                           |                 |   |   |
| 13a. STATE  |  |  |  |  |   |  |                                    |  |                                      | 13b. CITY OR TOWN  |   | 13c. STREET ADDRESS  |                                   |                 |   |   |
| Maryland  |  |  |  |  |   |  |                                    |  |                                      | Frederick  |   | 321 N. Market Street   |                                   |                 |   |   |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |                                    |  |                                      | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |   |  |                                   |                 |   |   |
| FIRST MIDDLE LAST   |  |  |  |  | FIRST MIDDLE LAST   |  |                                    |  |                                      | 16b. SOCIAL SECURITY NO.   |   |  |                                   |                 |   |   |
| William Calvin Liday  |  |  |  |  | Mary Jane Smith   |  |                                    |  |                                      | 216-30-2989  |   |  |                                   |                 |   |   |
| 17. INFORMANT   |  |  |  |  |   |  |                                    |  |                                      | ADDRESS  |   |  |                                   |                 |   |   |
| Meredith Painter  |  |  |  |  |   |  |                                    |  |                                      | West 14th Street Frederick, Md.  |   |  |                                   |                 |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |  |   |  |                                    |  |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |                                   |                 |   |   |
| IMMEDIATE CAUSE (a) Congestive heart failure  |  |  |  |  |   |  |                                    |  |                                      | 24 hours   |   |  |                                   |                 |   |   |
| 4029 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardiovascular disease   |  |  |  |  |   |  |                                    |  |                                      | 5 years  |   |  |                                   |                 |   |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |   |  |                                    |  |                                      |  |   |  |                                   |                 |   |   |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |   |  |                                    |  |                                      |  |   |  |                                   |                 |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |   |  |                                    |  |                                      |  |   |  |                                   |                 |   |   |
| Cerebral edema secondary to cardiac arrest  |  |  |  |  |   |  |                                    |  |                                      |  |   |  |                                   |                 |   |   |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |                                    |  |                                      | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |                 |   |   |
|   |  |  |  |  |   |  |                                    |  |                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |                 |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  |                                    |  |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |                                   |                 |   |   |
|   |  |  |  |  | P.M. 19   |  |                                    |  |                                      |  |   |  |                                   |                 |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                                    |  |                                      | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |                                   |                 |   |   |
|   |  |  |  |  |   |  |                                    |  |                                      |  |   |  |                                   |                 |   |   |
| 22a. I certify that (I) (the doctor) attended the deceased from Jan 15 1969, to May 20 1982, that (I) (we) last saw the deceased alive on May 20 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |                                    |  |                                      |  |   |  |                                   |                 |   |   |
| 22b. SIGNATURE  |  |  |  |  |   |  |                                    |  |                                      | DEGREE   |   | 22c. DATE SIGNED   |                                   |                 |   |   |
| Henry V. Chase M.D.   |  |  |  |  |   |  |                                    |  |                                      | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 20 May 82  |                                   |                 |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |   |  |                                    |  |                                      | 22e. ADDRESS   |   |  |                                   |                 |   |   |
| Henry V. Chase M.D.   |  |  |  |  |   |  |                                    |  |                                      | 804 Toll House Ave Frederick MD  |   |  |                                   |                 |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  |                                      | 23d. LOCATION CITY OR TOWN COUNTY STATE  |   |  |                                   |                 |   |   |
| Burial  |  |  |  |  | 5/24/82   |  | Blue Ridge Cemetery                |  |                                      | Thurmont, Frederick, Md.   |   |  |                                   |                 |   |   |
| 24. FUNERAL DIRECTOR NAME   |  |  |  |  |   |  |                                    |  |                                      | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE                                     |                                   |                 |   |   |
| G. Douglas Stauffer Frederick, Md.  |  |  |  |  |   |  |                                    |  |                                      | JUN 2 1982   |   | [Signature]  |                                   |                 |   |   |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

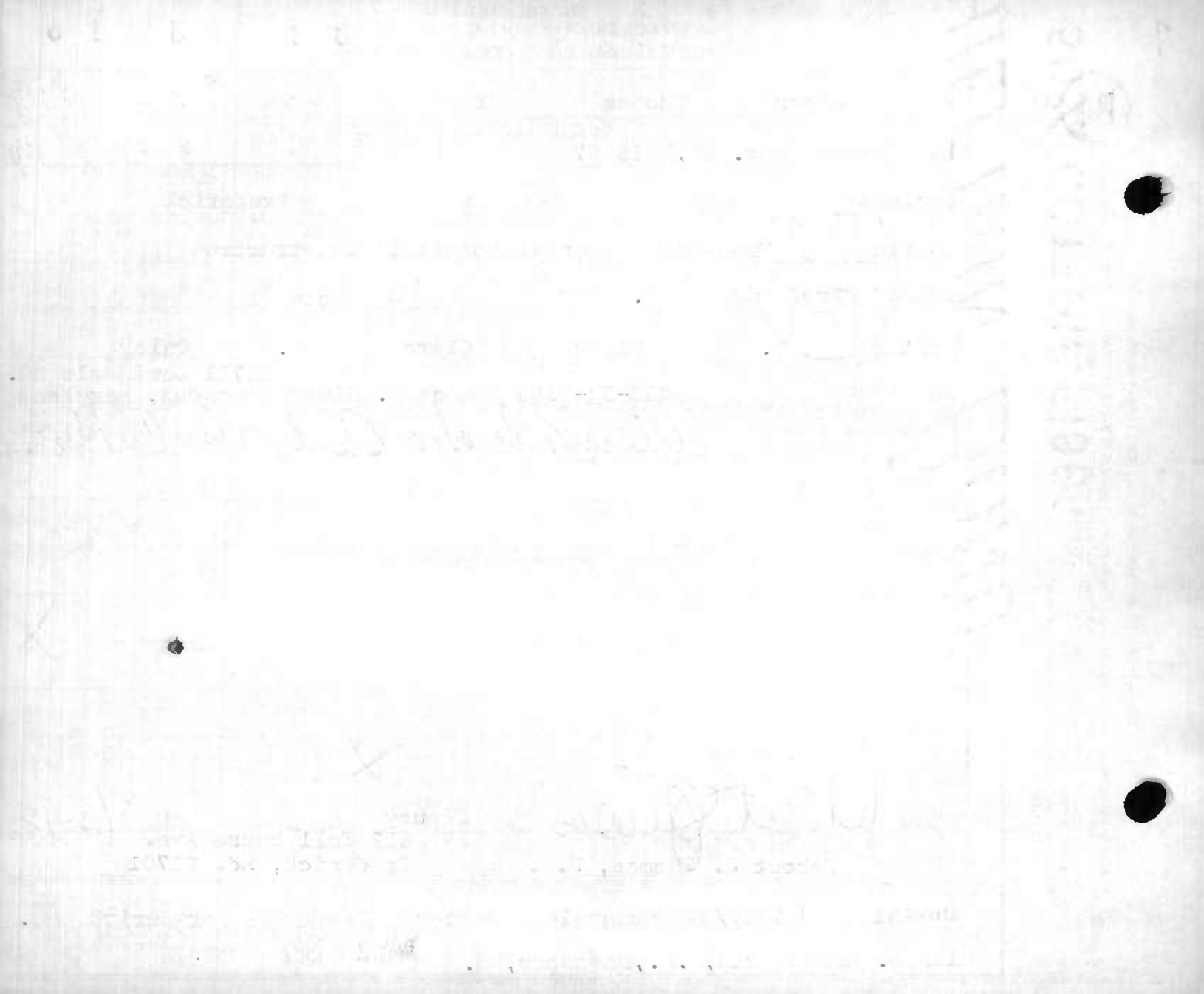
DHMH-17  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |                         |  |   |   |                               |
|---|-------------------------|--|---|---|-------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Walter Thomas SIMMS</b>   |                         |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br><input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR<br><b>5 27 19 82</b> |   | 2b. HOUR<br><b>1 15</b>       |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Negro</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Apr. 19, 1915</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67 YRS.</b>   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   | IF UNDER 24 HRS.<br>HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                               |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Construction</b>  |                               |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>Frederick</b>  |   | 13c. CITY OR TOWN<br><b>Mt. Airy</b>  |                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter T. Simms</b>  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Clara F. Onley</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>213-32-8505</b>   |   | 17. INFORMANT<br><b>Thomas E. Simms</b>   |                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Interventricular Cardiacs with Atherosclerosis</b><br>(c) <b>4292</b>  |                         | 19. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Clara F. Onley</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>  |                               |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |  |   |   |                               |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   | 18. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                               |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                               |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |   |   |                               |
| ACTUAL SIGNATURE<br><b>Robert J. Thomas</b>   |                         | TITLE (SPECIFY)<br><b>Deputy</b>   |   | DATE SIGNED<br><b>5/27/82</b>   |                               |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Robert J. Thomas, M.D.</b>   |                         | ADDRESS<br><b>Frederick, Md. 21701</b>   |   | MEDICAL EXAMINER<br><b>812 Toll House Ave.</b>  |                               |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>5/27/82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunnyside Cemetery</b>   |                               |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Olin L. Molesworth, P.A.,</b>  |                         | ADDRESS<br><b>Damascus, Md.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 27 1982</b>   |                               |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |                         | 25c. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |   |                               |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |  |  |  | 8 2 1 3 0 1 7   |  |
|--|--|--|--|--|--|--|--|--|--|---|--|
| FOR<br>1- STATE<br>REGISTRAR   |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH   |  |
| Paul Dittmar SIMPSON   |  |  |  |  |  |  |  |  |  | May 23, 1982  |  |
| 3. SEX   |  |  |  |  |  |  |  |  |  | 2b. HOUR  |  |
| Male   |  |  |  |  |  |  |  |  |  | 1 p.m.  |  |
| 4. RACE  |  |  |  |  |  |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
| White  |  |  |  |  |  |  |  |  |  | 86  |  |
| 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 8. YRS.   |  |
| March 7, 1896  |  |  |  |  |  |  |  |  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Maryland   |  |  |  |  |  |  |  |  |  | Frederick County, MD.   |  |
| 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |
| U.S.A.   |  |  |  |  |  |  |  |  |  | Supervisor  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Frederick  |  |  |  |  |  |  |  |  |  | ST. OF MD.  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  |  |  |  |  |  |  |  |  |   |  |
| Frederick Nursing Center   |  |  |  |  |  |  |  |  |  |   |  |
| 13a. STATE   |  |  |  |  |  |  |  |  |  | 13b. INSIDE CITY LIMITS?  |  |
| Maryland   |  |  |  |  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 13c. CITY OR TOWN  |  |  |  |  |  |  |  |  |  | 13d. STREET ADDRESS   |  |
| Frederick  |  |  |  |  |  |  |  |  |  | Brooklawn Apts.   |  |
| 14. FATHER'S NAME  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |
| Ridgely D. Simpson   |  |  |  |  |  |  |  |  |  | A. Florence Albaugh   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.  |  |
| Yes  |  |  |  |  |  |  |  |  |  | 214-10-1254   |  |
| 17. INFORMANT  |  |  |  |  |  |  |  |  |  | 18. CAUSE OF DEATH  |  |
| Mrs. Doris L. Felton; 823 North Market St., Frederick, Md. 21701   |  |  |  |  |  |  |  |  |  | Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>3320<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Parkinson's Disease</u><br>(c) <u></u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u></u>   |  |  |  |  |  |  |  |  |  |   |  |
| MEDICAL CERTIFICATION  |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  |   |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  |  |  |  |  |   |  |
| 20a. AUTOPSY?  |  |  |  |  |  |  |  |  |  |   |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |  |  |  |  |  |  |   |  |
| YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |  |  |  |  |   |  |
| 21b. TIME OF INJURY  |  |  |  |  |  |  |  |  |  |   |  |
| HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |  |  |  |  |   |  |
| P.M. 19  |  |  |  |  |  |  |  |  |  |   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED   |  |  |  |  |  |  |  |  |  |   |  |
| 21e. PLACE OF INJURY   |  |  |  |  |  |  |  |  |  |   |  |
| 21f. LOCATION  |  |  |  |  |  |  |  |  |  |   |  |
| CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>many years</u> to <u>5/23/82</u> , that (I) (we) last saw the deceased alive on <u>5/23/82</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  |   |  |
| DEGREE   |  |  |  |  |  |  |  |  |  |   |  |
| 22c. DATE SIGNED   |  |  |  |  |  |  |  |  |  |   |  |
| 5/24/82  |  |  |  |  |  |  |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |  |  |  |  |  |   |  |
| 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |   |  |
| Dr. A. Austin Pearre, Jr. MD 804 Toll House Ave., Fred. Md. 21701  |  |  |  |  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  |  |  |  |  |  |  |   |  |
| 23b. DATE  |  |  |  |  |  |  |  |  |  |   |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  |   |  |
| 23d. LOCATION  |  |  |  |  |  |  |  |  |  |   |  |
| CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |   |  |
| Burial May 26, 1982 Mt. Olivet Cemetery Frederick Frederick Md.  |  |  |  |  |  |  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  |   |  |
| 25a. DATE REGD. BY REGISTRAR   |  |  |  |  |  |  |  |  |  |   |  |
| 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |   |  |
| Smith Keeney Sanford P.A. Funeral Home MAY 26 1982   |  |  |  |  |  |  |  |  |  |   |  |
| 106 E. Church St., Frederick, Md. 21701  |  |  |  |  |  |  |  |  |  |   |  |

BP

May 25, 1982

White

Frederick

Frederick

Frederick

Frederick

Frederick

Frederick

Frederick

Frederick

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |  | 8 2 1 3 0 1 8  |  |
|---|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
| FIRST <b>Forrest</b> MIDDLE <b>Bradley</b> LAST <b>SNYDER</b><br><b>FORREST BRADLEY SNYDER</b>  |  |  | MONTH <b>May</b> DAY <b>22</b> YEAR <b>1982</b>               |  | 1:40 P.M.  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                               |  | 7. IF UNDER 1 YEAR                                   |  |
| Male  | White  | MONTH <b>Nov.</b> DAY <b>22</b> YEAR <b>1910</b>   | 71 YRS.   |  | MONTHS <b>71</b> DAYS <b>71</b> HOURS <b>71</b> MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |  |  |
| Maryland  | USA  |  | Frederick Co., MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                    |  |
| Frederick   | Frederick Memorial Hospital  |  | Farmer  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS                                  |  |
| Maryland  |  | Frederick  | Frederick   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 8111 Cambridge Dr.                                   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |   |  |  |  |
| FIRST <b>Maurice</b> MIDDLE <b>M.</b> LAST <b>Snyder</b>  |  | FIRST <b>Edith</b> MIDDLE <b>E.</b> LAST <b>Purdum</b>   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |  |  |
| No  |  | 215-36-6921  |   | Sarah Royston Snyder, Item 13  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>5188</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>RESPIRATORY FAILURE</b><br>(c) <b>PNEUMONIA OR SEVERE OBSTRUCTIVE PULMONARY DISEASE</b> |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                   |
|   |  |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                         |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JANUARY</b> 19 <b>1978</b> , to <b>MAY 22</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>MAY 22</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.     |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>George I. Smith, Jr.</b>   |  |  |   | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>22/MAY 82</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George I. Smith, Jr., M.D.</b>  |  |  |   | 22e. ADDRESS<br><b>804 Toll House Ave., Frederick, Md.</b>                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>May 25, 1982</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bethesda Meth.</b>                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Browningsville, Montg., Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Orin L. Molesworth, P.A., Damascus, Md.</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 26 1982</b>                            |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                 |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 1 3 0 1 9

REG. NO.

|  |  |   |   |  |  |   |  |  |   |  |  |
|--|--|---|---|--|--|---|--|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Charles Edward STUNKLE   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>May 28, 1982                    |  |  | 2b HOUR<br>11:30 A M  |  |  |   |  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug 7, 1897   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.   |  | 7 UNDER 1 YEAR<br>MONTHS DAYS<br>HOURS MIN.  |   |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County, MD.                        |  |  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br>Frederick  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Frederick Nursing Center |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Farmer           |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Farming  |   |  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Maryland   |  |   | 13b COUNTY<br>Frederick   |  | 13c CITY OR TOWN<br>Point of Rocks                       |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br>1522 Ballenger Creek Pike |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frederick J. Stunkle   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Pearl Fry   |  |   |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>None 727-09-6503 |  |
| 17 INFORMANT<br>Mrs. Lizzie Stunkle, Point of Rocks, Md.   |  |   |   | 17 ADDRESS<br>1522 Ballenger Creek Pike  |  |   |  | 17   |   | 17   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cong. Arty. Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>2 yrs.</u>                        |  |   |   |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>8 hrs   |   | 277  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |  |  |   |  |  |   |  |  |
| 19a DATE OF OPERATION  |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |   |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |   |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |   |  |  |   |  |  |
| 22b SIGNATURE<br><u>Robert L. Kaufmann, MD</u><br>DEGREE   |  |   |   |  |  | 22c DATE SIGNED<br>6/1/82   |  |  |   |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Robert L. Kaufmann, M.D.   |  |   |   |  |  | 22e ADDRESS<br>804 Toll House Ave., Frederick, Md. 21701                            |  |  |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b DATE<br>June 1, 1982  |  | 23c NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet Cemetery |   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Frederick, Frederick, Md.   |   |  |  |
| 24 FUNERAL DIRECTOR<br><u>Edward C. Basford</u><br>Smith, Keeney and Basford Funeral Home<br>106 East Church St., Frederick, Md. 21701   |  |   |   |  |  | 25a DATED BY REGISTAR   |  |  | 25b REGISTRAR'S SIGNATURE                       |  |  |



8-2-13

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 1 3 0 2 0

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DOROTHY H. VANBENSCHOTEN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>5 13 82</b>   |   | 2b. HOUR<br><b>9:50 AM</b>                            |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 28, 1910</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS  |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Vermont</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Mem. Hosp.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>School Teacher</b>       |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Education</b> |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |   |   |
| 13a. STATE<br><b>D.C.</b>  | 13b. COUNTY<br><b>Frederick</b>  | 13c. CITY OR TOWN<br><b>Wash. D.C.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>2152 Florida Ave N.W. Wash. D.C.</b>                                      |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William vanBenschoten</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dorothy Marie Hadley</b>  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>579-12-8747</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>9918 Wistman Lane<br/>Katrina v.B. Darnell Myersville, Md. 21773</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |   |   |   |
| 19a. DATE OF OPERATION<br><b>11/15/81</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Emphysema</b>  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>NO</b>         |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 15, 1982</b> , to <b>May 13, 1982</b> , that (I) (we) last saw the deceased alive on <b>May 14, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                                  |  |   |   |   |   |
| 22b. SIGNATURE<br><b>Theresa Johnson</b>   |  | DEGREE<br><b>Attending Physician</b>  |   | 22c. DATE SIGNED<br><b>5/13/82</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lisa Johnson</b>   |  | 22e. ADDRESS<br><b>198 Thomas Johnson Frederick, Md.</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>5-14-82</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Park</b>                                     |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Balto. Md.</b>  |  | 23e. DATE REC'D. BY REGISTRAR<br><b>MAY 14 1982</b>   |   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Salamone Funeral Home</b>   |  | ADDRESS<br><b>Frederick, Md, 21701</b>  |   | 25. REGISTRAR'S SIGNATURE<br><b>Theresa Johnson</b>   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |   |                     |  |  |
|---|--|---|--|---|--|---|---------------------|--|--|
| 8 2 1 3 0 2 1<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |                     |  |  |
| REG. NO.  |  |   |  |   |  |   |                     |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Sarah Helen WASKEY   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>May 26, 1982  |   | 2b. HOUR<br>6:45 AM |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>October 31, 1902  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS   |                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Frederick County, MD                                    |                     |  |  |
| 10. CITY OR TOWN OF DEATH<br>Braddock Heights   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Vindobona Nursing Home |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Post Mistress               |                     | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Government   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |                     |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Frederick  |  | 13c. CITY OR TOWN<br>Jefferson  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                     | 13e. STREET ADDRESS<br>2746 Lander Road  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles H. Waskey   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Virginia Shaff  |   |                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>None   |  | 17. INFORMANT<br>Mrs. H. Louise Hood  |  | ADDRESS<br>6303-A Paul Rudy Rd.<br>Middletown, Md. 21769  |                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Melastolic Lympho Sarcoma</u><br>2001<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Lympho Sarcoma Spleen</u><br>2 1/2 yrs<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Insure Clam</u> |  |   |  |   |  |   |                     |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |                     |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN  |                     | COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 1984</u> to <u>May 26, 1982</u> .<br>saw the deceased alive on <u>May 25, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |                     |  |  |
| 22b. SIGNATURE<br><u>G. T. Brice</u>  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |                     | 22c. DATE SIGNED<br>5/27/82  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. A. T. Brice, M.D.  |  |   |  |   | 22e. ADDRESS<br>Jefferson, Maryland 21755  |   |                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>May 28, 1982   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Frederick, Frederick, Md.                         |                     |  |  |
| 24. FUNERAL DIRECTOR<br><u>Robert C. C. Basford</u><br>Smith, Keeney and Basford Funeral Home<br>106 East Church St., Frederick, Md. 21701  |  |   |  |   |  | 25a. DATE<br>JUN 1 1982   |                     |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

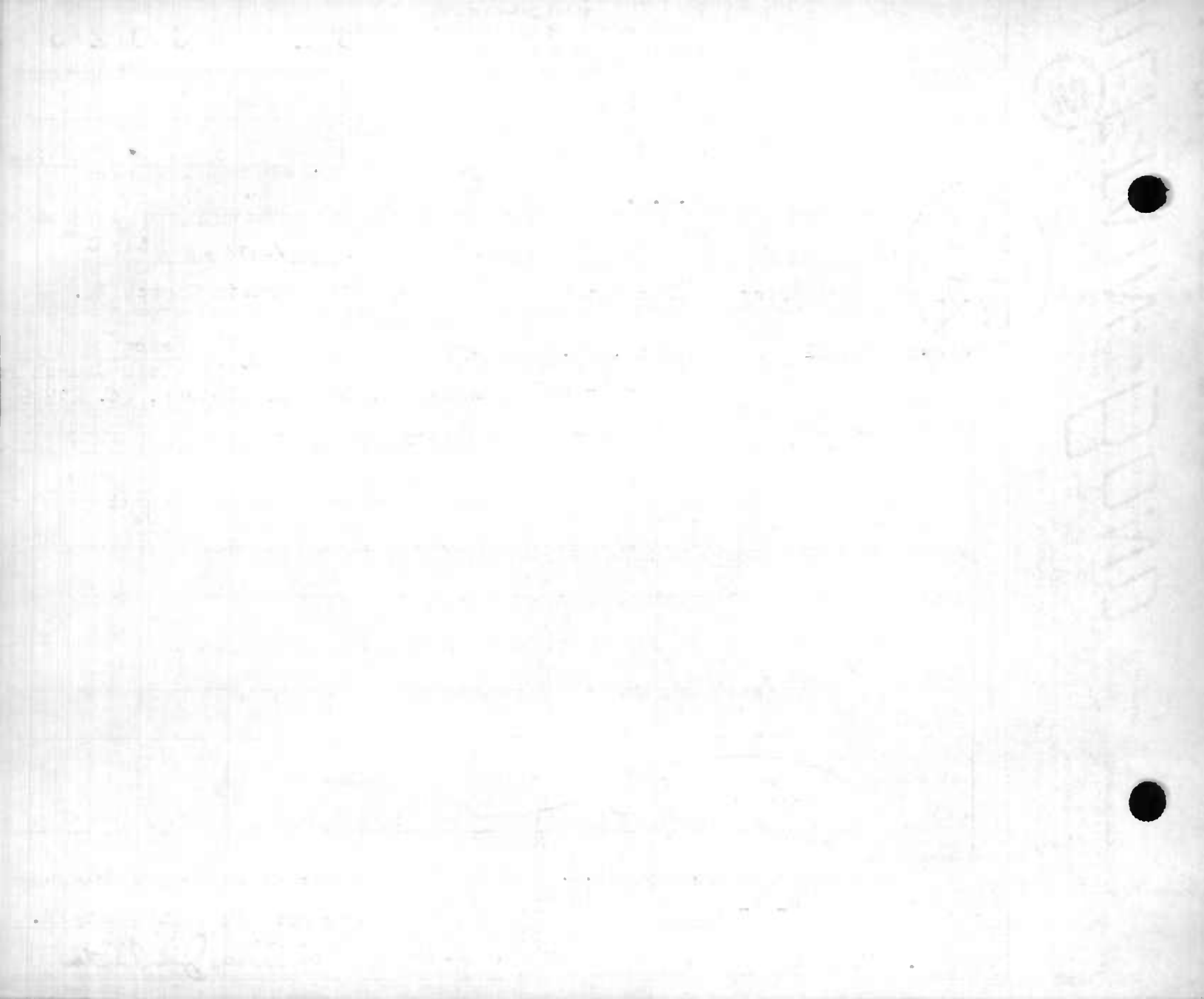
|  |  |   |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>IDA FIRST</b><br><b>IDA</b>   |  | 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 1, 1917</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>May 15, 82</b>   |  | 2b. HOUR<br><b>3:45</b> M                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Frederick</b> MD.                                    |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>H.wife</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |   |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Frederick</b>   |  | 13c. CITY OR TOWN<br><b>Frederick</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>8310 Peters Rd.</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Russell - Reed</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Josephine - Lilly</b>   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>042-22-9754</b>   |  | 17. INFORMANT ADDRESS<br><b>Darlene Sullivan Frederick, Md.</b>   |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b><br><b>4310</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)      |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/12</b> 19 <b>82</b> , to <b>5/15</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>5/14</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Robert S. Hughes</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>5/15/82</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert S. Hughes</b>   |  |   |  | 22e. ADDRESS<br><b>Frederick, Maryland</b>  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>May 18, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Laytonsville Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laytonsville, Mont. Md.</b>                    |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Francis H. Barber Laytonsville, Md. 20879</b>   |  |   |  |   |  | 25a. DATE RECEIVED BY REGISTRAR <b>MAY 15 1982</b><br>25b. HEALTH CARE PROVIDER SIGNATURE       |  |  |  |   |  |

RECEIVED 20:00M 11/11/00



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |   |   |   |  |   |   |  | REG. NO. 13023                               |  |
|--|-------------------------|--|---|---|---|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Mark Douglas Webber</b>   |                         |  |   |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> <b>5 11 19 82</b> |   | 2b. HOUR <b>M</b>   |  |  |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>16</b> YEAR <b>51</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>30</b> YRS.                 | IF UNDER 1 YR.<br>MONTHS <b></b> DAYS <b></b>   | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>                                | 2c. DATE PRONOUNCED DEAD<br><b>5 11 19 82</b>  |   | 2d. HOUR <b>8:28 PM</b>   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>FREDERICK COUNTY</b> MD.                        |   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frederick</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Frederick Memorial Hospital</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Foreman/welding</b>    |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel</b>                                   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. CITY OR TOWN<br><b>Frederick</b>  |   | 13c. CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13d. STREET ADDRESS<br><b>6621 Mountain Church Rd.</b>                                     |   |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>James Russell</b> MIDDLE <b></b> LAST <b>Webber, Sr.</b>   |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Joyce</b> MIDDLE <b>Juanita</b> LAST <b>Hawes</b>  |   |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>no</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>220-54-3669</b>   |   | 17. INFORMANT<br><b>Garnetta Webber</b> ADDRESS <b>6621 Mountain Church Rd. Middletown, Md. 21769</b>   |   |  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <b></b><br>(c) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |                         |  |   |   |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION   |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |   |   |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b> |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)       |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |                         |  |   |   |   |  |   |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Thomas D. Smith, M.D.</b>   |                         |  | TITLE (SPECIFY)<br><b>Deputy Chief</b>                            |   |   |  |   | DATE SIGNED<br><b>5/12/82</b>   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>   |                         |  | ADDRESS<br><b>111 Penn Street, Baltimore, MD 21201</b>            |   |   |  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |                         | 23b. DATE<br><b>5-14-82</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Brownsville Heights</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brownsville Washington Md.</b>            |   |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John T. Williams</b>  |                         |  | ADDRESS<br><b>100 Petersville</b>                                 |   | DATE REC'D. BY REGISTRAR<br><b>MAY 21 1982</b>                                |  | 25. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b> |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 1 3 0 2 4

REG. NO.

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)KATHARINA  
KATHARINA

MIDDLE

LAST

H. Wentzel

2a. DATE OF DEATH

MONTH

DAY

YEAR

5/24/82

2b. HOUR

8 04 AM

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

July 24, 1926

6. AGE (IN YEARS LAST BIRTHDAY)

55

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a. BIRTHPLACE  
(STATE OR FOREIGN  
COUNTRY)

Germany

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Frederick County

MD.

10. CITY OR TOWN OF DEATH

Frederick

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Frederick Memorial Hospital

12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)12b. KIND OF BUSINESS OR  
INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Pennsylvania

13b. COUNTY

Berks

13c. CITY OR TOWN

Reading

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

1006 S. 15th St.

507 S. 15th St.

14. FATHER'S NAME

Unknown

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

Alma

MIDDLE

LAST

Huck

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

- - - - -

16c. SOCIAL SECURITY NO.

210-24-3648

16d. DECEASED NAME

Walter Wentzel

ADDRESS

1046 Scott St, Reading, Pa. 19611

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4100

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Aspiration pneumonia

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☒ NO ☐20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☒ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 5-23-1982, to 5-24-1982, that (I) (we) last saw the deceased alive on 5-24-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING  
PHYSICIANMEDICAL  
DIRECTORSTAFF  
PHYSICIAN

22c. DATE SIGNED

5/24/82

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

BARAKAT KUSAY

22e. ADDRESS

335 Park Aven. Frederick MD 21701

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Removal- Burial

23b. DATE

May 28, 1982

23c. NAME OF CEMETERY OR CREMATORY

Forest Hills Mem. Pk.

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Exeter-Township, Berks, Pa.

24. FUNERAL DIRECTOR

Smith, Keeney and Basford  
106 East Church St. Frederick, MD 21701

25a. DATE REC'D. BY REGISTRAR

MAY 27 1982

25b. REGISTRAR'S SIGNATURE

[Signature]

$\frac{d}{dt} \left( \frac{\partial L}{\partial \dot{x}} \right) = \frac{\partial L}{\partial x}$

10501 40 7211

22.

187

### Integrierte Lernaktivitäten

Country: China

44

\* 文苑英華卷之四

1000 West St. Building 1A 10011

442-15-016

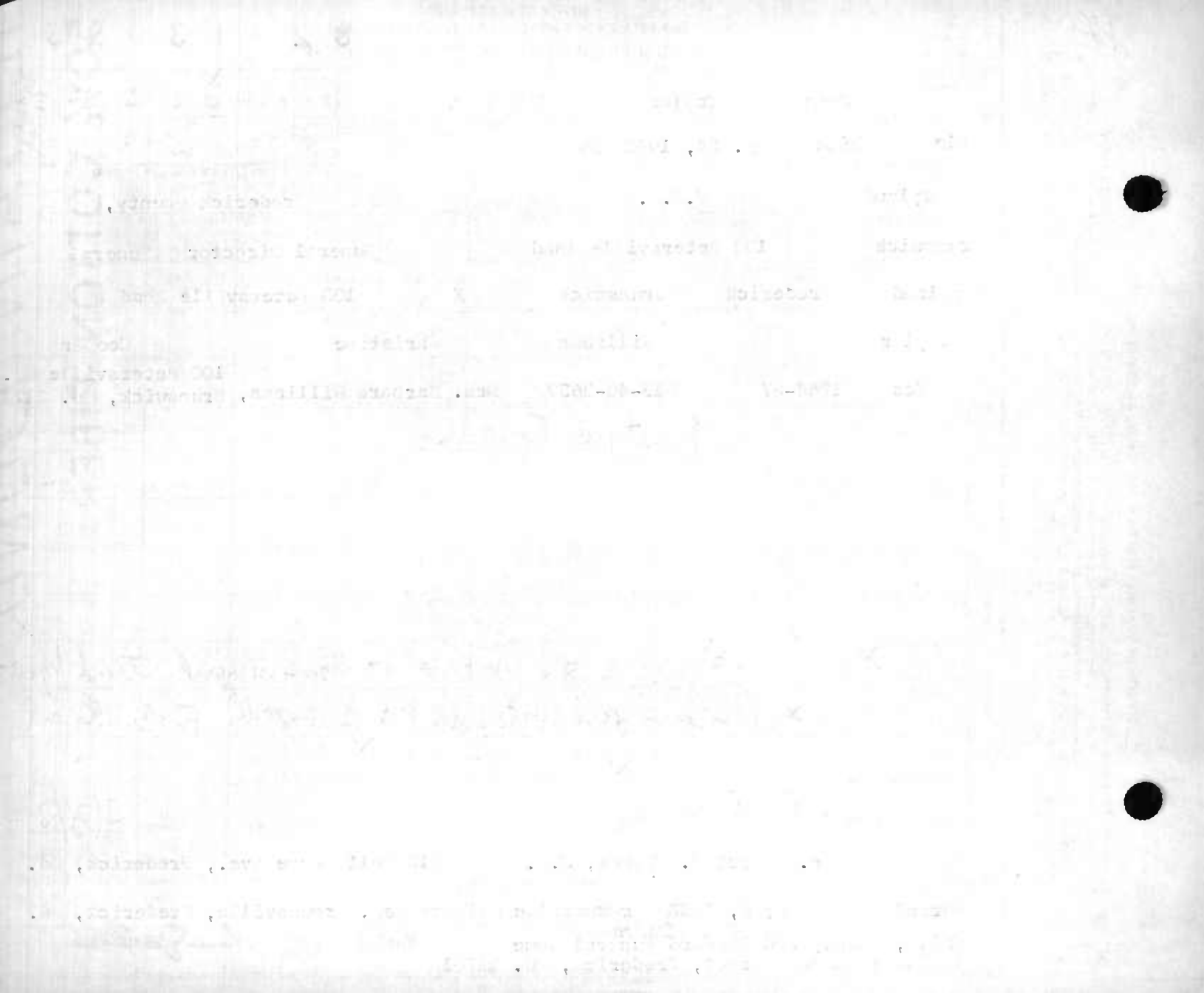
— — — —

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |  |   |  |  |  |  |                           | REG. NO. 13025   |  |
|---|--|----------------------|--|---|--|--|--|--|---------------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |                      |  |   |  |  |  |  |                           |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>John Taylor WILLIAMS</b>  |  |                      |  |   |  |  |  |  |                           | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>5</b> DAY <b>2</b> YEAR <b>1982</b> 2b. HOUR <b>3:30</b> AM |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b> |  | 5. DATE OF BIRTH MONTH <b>Aug.</b> DAY <b>24</b> YEAR <b>1942</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>39</b> YRS.   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN   |                           | 7c. DATE PRONOUNCED DEAD MONTH <b>5</b> DAY <b>2</b> YEAR <b>1982</b> 7d. HOUR <b>3:30</b> PM                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Frederick County, MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>Brunswick</b>  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>100 Petersville Road</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Funeral Director</b>  |                           | 12b. KIND OF BUSINESS OR INDUSTRY <b>Funeral</b>   |  |
| 13a. STATE <b>Maryland</b>  |  |                      |  | 13b. CITY OR TOWN <b>Frederick</b>  |  | 13c. CITY OR TOWN <b>Brunswick</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                           | 13e. STREET ADDRESS <b>100 Petersville Road</b>  |  |
| 14. FATHER'S NAME FIRST <b>Taylor</b> MIDDLE LAST <b>Williams</b>   |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Christine</b> MIDDLE LAST <b>Cooper</b>  |  |  |                           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>   |  |                      |  | 16b. SOCIAL SECURITY NO. <b>1964-67</b>   |  | 17. INFORMANT ADDRESS <b>100 Petersville Rd. Mrs. Barbara Williams, Brunswick, Md. 21711</b>                                 |  |  |                           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple Trauma.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                      |  |   |  |  |  |  |                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                      |  |   |  |  |  |  |                           |  |  |
| 19a. DATE OF OPERATION  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |                           | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY HOUR <b>3:30</b> AM MONTH <b>5</b> DAY <b>2</b> YEAR <b>1982</b> P.M.   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Working at home in yard - struck by car</b> |  |  |                           |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home yard</b>  |  | 21f. LOCATION (STREET, CITY OR TOWN, COUNTY, STATE) <b>Petersville Rd Brunswick Frederick Md</b>                             |  |  |                           |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |  |  |  |                           |  |  |
| ACTUAL SIGNATURE <b>Robert Thomas</b>   |  |                      |  |   |  | TITLE (SPECIFY) _____  |  |  | DATE SIGNED <b>5/3/82</b> |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Dr. Robert J. Thomas, M.D.</b>   |  |                      |  |   |  | ADDRESS <b>812 Toll House Ave., Frederick, Md.</b>   |  |  |                           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |                      |  | 23b. DATE <b>May 5, 1982</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Brownsville Heights Cem.</b>   |  |  |                           | 23d. LOCATION (CITY OR TOWN, COUNTY, STATE) <b>Brownsville, Frederick, Md.</b>   |  |
| 24. FUNERAL DIRECTOR <b>Smith, Keeney and Bassford Funeral Home</b>   |  |                      |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAY 10 1982</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |                           |  |  |
| 106 East Church Street, Frederick, Md. 21701  |  |                      |  |   |  |  |  |  |                           |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |                     |   |  |                                  |  |
|--|--|--|--|---|---------------------|---|--|----------------------------------|--|
| <div style="display: flex; justify-content: space-between;"> <div> <p>1. FOR STATE REGISTRAR</p> </div> <div> <p>8 2 1 3 0 2 6</p> </div> </div>   |  |  |  |   |                     |   |  |                                  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |   | 2a. DATE OF DEATH   |   |  |                                  |  |
| FIRST MIDDLE LAST  |  |  |  |   | MONTH DAY YEAR HOUR |   |  |                                  |  |
| hind say SHROPSHIRE WYATT  |  |  |  |   | 5/11/82 5:45 PM     |   |  |                                  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |                     | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. IF UNDER 1 YEAR               |  |
| MALE   |  | WHITE  |  | OCT. 19-1946  |                     | 35  |  | MONTHS DAYS HOURS MIN.           |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 9. CITIZEN OF WHAT COUNTRY?  |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 11. BALTIMORE CITY OR COUNTY OF DEATH   |  | 12. MD.                          |  |
| VIRGINIA   |  | U.S.   |  |   |                     | FREDERICK   |  |                                  |  |
| 13. CITY OR TOWN OF DEATH  |  | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                     | 16. KIND OF BUSINESS OR INDUSTRY  |  |                                  |  |
| FREDERICK  |  | FREDERICK MEM. HOSPITAL  |  | CONSTRUCTION  |                     | SUP.T.  |  |                                  |  |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 18. CITY OR TOWN   |  | 19. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                     | 20. STREET ADDRESS  |  |                                  |  |
| MARYLAND   |  | FREDERICK  |  |   |                     | 8027 OLD RECEIVER RD  |  |                                  |  |
| 21. FATHER'S NAME (FIRST MIDDLE LAST)  |  | 22. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)   |  | 23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |                     | 24. SOCIAL SECURITY NO.   |  | 25. INFORMANT ADDRESS            |  |
| THEODORE   |  | WYATT ELLEN SHROPSHIRE   |  | NO  |                     | 213-467637  |  | THEODORE WYATT, UNION BRIDGE EMB |  |
| <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>hypo tension &amp; cardiac arrest</u></p> <p>1991</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last</p> <p>(b) <u>16-cm abdominal bleed</u> 12 hr</p> <p>(c) <u>undifferentiated carcinoma</u> 9 mo</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)</p> |  |  |  |   |                     |   |  |                                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                     |   |  |                                  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |                     |   |  |                                  |  |
| <p>22a. I certify that (I) (this hospital) attended the deceased from <u>5/10</u>, 19 <u>82</u>, to <u>5/11</u>, 19 <u>82</u>, that (I) (we) last saw the deceased alive on <u>5/10</u>, 19 <u>82</u>, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.</p>  |  |  |  |   |                     |   |  |                                  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED  |                     |   |  |                                  |  |
| <u>[Signature]</u> MD  |  |  |  | 5/11/82   |                     |   |  |                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 22f. MEDICAL ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |                     |   |  |                                  |  |
| D. G. Trausch  |  | 4 West Street  |  |   |                     |   |  |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |                     | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |                                  |  |
| CREMATION  |  | 5-11-82  |  | SMITHSBURG LRE  |                     | SMITHSBURG MD   |  |                                  |  |
| 24. FUNERAL DIRECTOR   |  | 24a. ADDRESS   |  | 24b. DATE REC'D BY REGISTRAR  |                     | 24c. REGISTRAR'S SIGNATURE  |  |                                  |  |
| D. D. Hartley  |  | Union Bridge   |  | MAY 14 1982   |                     | James J. Nathan   |  |                                  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |                   |  |   |  |                     |  |  |
|--|--|--|--|--|-------------------|--|---|--|---------------------|--|--|
| 1. FOR STATE REGISTRAR   |  | 8 2 1 3 0 2 7  |  |  |                   |  |   |  |                     |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |                   | LAST   |   | 2a. DATE OF DEATH MONTH DAY YEAR                               |                     |  |  |
| CHARLES WILLIAM YINGER   |  |  |  |  |                   |  |   | 5 / 18 / 82  |                     |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |                   | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | 7b. HOUR   |                     |  |  |
| M  |  | W  |  | 9 29 24  |                   | 57   |   | 830 P.M.   |                     |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |                     |  |  |
| MD   |  | USA  |  |  |                   | Frederick Co   |   | MD.  |                     |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |                     |  |  |
| Frederick  |  | Frederick Memorial Hosp  |  |  |                   | US Army  |   | U.S. Army  |                     |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  | 13b. CITY OR TOWN |  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS |  |  |
| MD   |  |  |  |  | Frederick         |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 500 Biggs Ave       |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |                   |  |   |  |                     |  |  |
| John E Yinger  |  | Elva E Ziegler   |  |  |                   |  |   |  |                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 16c. DECEASED ADDRESS  |                   |  |   |  |                     |  |  |
| YES  |  | WW11   |  | 217-12-452   |                   | 500 Biggs Ave. Frederick, MD 21701   |   |  |                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |                   |  |   |  |                     |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |                   |  |   |  |                     |  |  |
| IMMEDIATE CAUSE (a) <u>cardiogenic shock</u>   |  |  |  |  |                   |  |   |  |                     |  |  |
| 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute myocardial infarct</u>  |  |  |  |  |                   |  |   |  |                     |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>chronic heart disease</u>  |  |  |  |  |                   |  |   |  |                     |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>none</u>   |  |  |  |  |                   |  |   |  |                     |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |                   | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                     |  |  |
|  |  |  |  |  |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                     |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                   |  |   |  |                     |  |  |
|  |  | P.M. 19  |  |  |                   |  |   |  |                     |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                   |  |   |  |                     |  |  |
|  |  |  |  |  |                   |  |   |  |                     |  |  |
| 22a. I certify that (this hospital) attended the deceased from <u>5-14</u> , 19 <u>82</u> , to <u>5-18</u> , 19 <u>82</u> that (I) (we) last saw the deceased alive on <u>5-18</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |  |  |  |                   |  |   |  |                     |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  |  |                   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED   |                     |  |  |
| S. Kahan   |  | MD   |  |  |                   |  |   | 5-18-82  |                     |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |                   |  |   |  |                     |  |  |
| S. KAHAN   |  | 335 Park Ave Frederick MD  |  |  |                   |  |   |  |                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                   | 23d. LOCATION CITY OR TOWN COUNTY STATE  |   |  |                     |  |  |
| Burial   |  | May 22, 1982   |  | Mount Olivet Cem.  |                   | Frederick Frederick MD   |   |  |                     |  |  |
| 24. FUNERAL DIRECTOR'S NAME  |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |                   | 25b. REGISTRAR'S SIGNATURE   |   |  |                     |  |  |
| Smith, Keeney and Basford  |  | 106 East Church St. Frederick, MD 21701  |  | MAY 24 1982  |                   | Name [Signature]   |   |  |                     |  |  |

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